

104TH CONGRESS  
2D SESSION

# H. R. 3103

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## AN ACT

To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

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erage, to simplify the administration of health insurance,  
and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Health Coverage Availability and Affordability Act of  
6 1996”.

7 (b) TABLE OF CONTENTS.—The table of contents of  
8 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF  
HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

Sec. 101. Portability of coverage for previously covered individuals.

Sec. 102. Limitation on preexisting condition exclusions; no application to cer-  
tain newborns, adopted children, and pregnancy.

Sec. 103. Prohibiting exclusions based on health status and providing for en-  
rollment periods.

Sec. 104. Enforcement.

Subtitle B—Certain Requirements for Insurers and HMOs in the Group and  
Individual Markets

PART 1—AVAILABILITY OF GROUP HEALTH INSURANCE COVERAGE

Sec. 131. Guaranteed availability of general coverage in the small group mar-  
ket.

Sec. 132. Guaranteed renewability of group coverage.

PART 2—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

Sec. 141. Guaranteed availability of individual health insurance coverage to cer-  
tain individuals with prior group coverage.

Sec. 142. Guaranteed renewability of individual health insurance coverage.

PART 3—ENFORCEMENT

Sec. 151. Incorporation of provisions for State enforcement with Federal fall-  
back authority.

Subtitle C—Affordable and Available Health Coverage Through Multiple  
Employer Pooling Arrangements

Sec. 161. Clarification of duty of the Secretary of Labor to implement provisions of current law providing for exemptions and solvency standards for multiple employer health plans.

“PART 7—RULES GOVERNING REGULATION OF MULTIPLE EMPLOYER  
HEALTH PLANS

“Sec. 701. Definitions.

“Sec. 702. Clarification of duty of the Secretary to implement provisions of current law providing for exemptions and solvency standards for multiple employer health plans.

“Sec. 703. Requirements relating to sponsors, boards of trustees, and plan operations.

“Sec. 704. Other requirements for exemption.

“Sec. 705. Maintenance of reserves.

“Sec. 706. Notice requirements for voluntary termination.

“Sec. 707. Corrective actions and mandatory termination.

“Sec. 708. Additional rules regarding State authority.

Sec. 162. Affordable and available fully insured health coverage through voluntary health insurance associations.

Sec. 163. State authority fully applicable to self-insured multiple employer welfare arrangements providing medical care which are not exempted under new part 7.

Sec. 164. Clarification of treatment of single employer arrangements.

Sec. 165. Clarification of treatment of certain collectively bargained arrangements.

Sec. 166. Treatment of church plans.

Sec. 167. Enforcement provisions relating to multiple employer welfare arrangements.

Sec. 168. Cooperation between Federal and State authorities.

Sec. 169. Filing and disclosure requirements for multiple employer welfare arrangements offering health benefits.

Sec. 170. Single annual filing for all participating employers.

Sec. 171. Effective date; transitional rule.

Subtitle D—Definitions; General Provisions

Sec. 191. Definitions; scope of coverage.

Sec. 192. State flexibility to provide greater protection.

Sec. 193. Effective date.

Sec. 194. Rule of construction.

Sec. 195. Findings relating to exercise of commerce clause authority.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE;  
ADMINISTRATIVE SIMPLIFICATION; MEDICAL LIABILITY REFORM

Sec. 200. References in title.

Subtitle A—Fraud and Abuse Control Program

Sec. 201. Fraud and abuse control program.

Sec. 202. Medicare integrity program.

Sec. 203. Beneficiary incentive programs.

Sec. 204. Application of certain health anti-fraud and abuse sanctions to fraud and abuse against Federal health care programs.

Sec. 205. Guidance regarding application of health care fraud and abuse sanctions.

#### Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

- Sec. 211. Mandatory exclusion from participation in medicare and State health care programs.
- Sec. 212. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.
- Sec. 213. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.
- Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations.
- Sec. 215. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 216. Additional exception to anti-kickback penalties for discounting and managed care arrangements.
- Sec. 217. Criminal penalty for fraudulent disposition of assets in order to obtain medicaid benefits.
- Sec. 218. Effective date.

#### Subtitle C—Data Collection

- Sec. 221. Establishment of the health care fraud and abuse data collection program.

#### Subtitle D—Civil Monetary Penalties

- Sec. 231. Social security act civil monetary penalties.
- Sec. 232. Clarification of level of intent required for imposition of sanctions.
- Sec. 233. Penalty for false certification for home health services.

#### Subtitle E—Revisions to Criminal Law

- Sec. 241. Definitions relating to Federal health care offense.
- Sec. 242. Health care fraud.
- Sec. 243. Theft or embezzlement.
- Sec. 244. False statements.
- Sec. 245. Obstruction of criminal investigations of health care offenses.
- Sec. 246. Laundering of monetary instruments.
- Sec. 247. Injunctive relief relating to health care offenses.
- Sec. 248. Authorized investigative demand procedures.
- Sec. 249. Forfeitures for Federal health care offenses.
- Sec. 250. Relation to ERISA authority.

#### Subtitle F—Administrative Simplification

- Sec. 251. Purpose.
- Sec. 252. Administrative simplification.

#### “PART C—ADMINISTRATIVE SIMPLIFICATION

- “Sec. 1171. Definitions.
- “Sec. 1172. General requirements for adoption of standards.
- “Sec. 1173. Standards for information transactions and data elements.
- “Sec. 1174. Timetables for adoption of standards.
- “Sec. 1175. Requirements.
- “Sec. 1176. General penalty for failure to comply with requirements and standards.

“Sec. 1177. Wrongful disclosure of individually identifiable health information.

“Sec. 1178. Effect on State law.

Sec. 253. Changes in membership and duties of National Committee on Vital and Health Statistics.

#### Subtitle G—Duplication and Coordination of Medicare-Related Plans

Sec. 261. Duplication and coordination of medicare-related plans.

#### Subtitle H—Medical Liability Reform

##### PART 1—GENERAL PROVISIONS

Sec. 271. Federal reform of health care liability actions.

Sec. 272. Definitions.

Sec. 273. Effective date.

##### PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

Sec. 281. Statute of limitations.

Sec. 282. Calculation and payment of damages.

Sec. 283. Alternative dispute resolution.

##### TITLE III—TAX-RELATED HEALTH PROVISIONS

Sec. 300. Amendment of 1986 code.

#### Subtitle A—Medical Savings Accounts

Sec. 301. Medical savings accounts.

#### Subtitle B—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

Sec. 311. Increase in deduction for health insurance costs of self-employed individuals.

#### Subtitle C—Long-Term Care Services and Contracts

##### PART I—GENERAL PROVISIONS

Sec. 321. Treatment of long-term care insurance.

Sec. 322. Qualified long-term care services treated as medical care.

Sec. 323. Reporting requirements.

##### PART II—CONSUMER PROTECTION PROVISIONS

Sec. 325. Policy requirements.

Sec. 326. Requirements for issuers of long-term care insurance policies.

Sec. 327. Coordination with State requirements.

Sec. 328. Effective dates.

#### Subtitle D—Treatment of Accelerated Death Benefits

Sec. 331. Treatment of accelerated death benefits by recipient.

Sec. 332. Tax treatment of companies issuing qualified accelerated death benefit riders.

#### Subtitle E—High-Risk Pools

Sec. 341. Exemption from income tax for State-sponsored organizations providing health coverage for high-risk individuals.

Subtitle F—Organizations Subject to Section 833

Sec. 351. Organizations subject to section 833.

TITLE IV—REVENUE OFFSETS

Sec. 400. Amendment of 1986 Code.

Subtitle A—Repeal of Bad Debt Reserve Method for Thrift Savings Associations

Sec. 401. Repeal of bad debt reserve method for thrift savings associations.

Subtitle B—Reform of the Earned Income Credit

Sec. 411. Earned income credit denied to individuals not authorized to be employed in the United States.

Subtitle C—Treatment of Individuals Who Lose United States Citizenship

Sec. 421. Revision of income, estate, and gift taxes on individuals who lose United States citizenship.

Sec. 422. Information on individuals losing United States citizenship.

Sec. 423. Report on tax compliance by United States citizens and residents living abroad.

**1 TITLE I—IMPROVED AVAILABIL-**  
**2 ITY AND PORTABILITY OF**  
**3 HEALTH INSURANCE COV-**  
**4 ERAGE**

**5 Subtitle A—Coverage Under Group**  
**6 Health Plans**

**7 SEC. 101. PORTABILITY OF COVERAGE FOR PREVIOUSLY**  
**8 COVERED INDIVIDUALS.**

**9 (a) CREDITING PERIODS OF PREVIOUS COVERAGE**  
**10 TOWARD PREEXISTING CONDITION RESTRICTIONS.—Sub-**  
**11 ject to the succeeding provisions of this section, a group**  
**12 health plan, and an insurer or health maintenance organi-**  
**13 zation offering health insurance coverage in connection**

1 with a group health plan, shall provide that any preexist-  
 2 ing condition limitation period (as defined in subsection  
 3 (b)(2)) is reduced by the length of the aggregate period  
 4 of qualified prior coverage (if any, as defined in subsection  
 5 (b)(3)) applicable to the participant or beneficiary as of  
 6 the date of commencement of coverage under the plan.

7 (b) DEFINITIONS AND OTHER PROVISIONS RELAT-  
 8 ING TO PREEXISTING CONDITIONS.—

9 (1) PREEXISTING CONDITION.—

10 (A) IN GENERAL.—For purposes of this  
 11 subtitle, subject to subparagraph (B), the term  
 12 “preexisting condition” means a condition, re-  
 13 gardless of the cause of the condition, for which  
 14 medical advice, diagnosis, care, or treatment  
 15 was recommended or received within the 6-  
 16 month period ending on the day before—

17 (i) the effective date of the coverage  
 18 of such participant or beneficiary, or

19 (ii) the earliest date upon which such  
 20 coverage could have been effective if there  
 21 were no waiting period applicable,

22 whichever is earlier.

23 (B) TREATMENT OF GENETIC INFORMA-  
 24 TION.—For purposes of this section, genetic in-  
 25 formation shall not be considered to be a pre-



existing condition, so long as treatment of the condition to which the information is applicable has not been sought during the 6-month period described in subparagraph (A).

(2) PREEXISTING CONDITION LIMITATION PERIOD.—For purposes of this subtitle, the term “pre-existing condition limitation period” means, with respect to coverage of an individual under a group health plan or under health insurance coverage, the period during which benefits with respect to treatment of a condition of such individual are not provided based on the fact that the condition is a pre-existing condition.

(3) AGGREGATE PERIOD OF QUALIFIED PRIOR COVERAGE.—

(A) IN GENERAL.—For purposes of this section, the term “aggregate period of qualified prior coverage” means, with respect to commencement of coverage of an individual under a group health plan or health insurance coverage offered in connection with a group health plan, the aggregate of the qualified coverage periods (as defined in subparagraph (B)) of such individual occurring before the date of such commencement. Such period shall be treated as

1 zero if there is more than a 60-day break in  
2 coverage under a group health plan (or health  
3 insurance coverage offered in connection with  
4 such a plan) between the date the most recent  
5 qualified coverage period ends and the date of  
6 such commencement.

7 (B) QUALIFIED COVERAGE PERIOD.—

8 (i) IN GENERAL.—For purposes of  
9 this paragraph, subject to subsection (c),  
10 the term “qualified coverage period”  
11 means, with respect to an individual, any  
12 period of coverage of the individual under  
13 a group health plan, health insurance cov-  
14 erage, under title XVIII or XIX of the So-  
15 cial Security Act, coverage under the  
16 TRICARE program under chapter 55 of  
17 title 10, United States Code, a program of  
18 the Indian Health Service, and State  
19 health insurance coverage or risk pool, and  
20 includes coverage under a health plan of-  
21 fered under chapter 89 of title 5, United  
22 States Code.

23 (ii) DISREGARDING PERIODS BEFORE  
24 BREAKS IN COVERAGE.—Such term does  
25 not include any period occurring before

1           any 60-day break in coverage described in  
2           subparagraph (A).

3           (C) WAITING PERIOD NOT TREATED AS A  
4           BREAK IN COVERAGE.—For purposes of sub-  
5           paragraphs (A) and (B), any period that is in  
6           a waiting period for any coverage under a  
7           group health plan (or for health insurance cov-  
8           erage offered in connection with a group health  
9           plan) shall not be considered to be a break in  
10          coverage described in subparagraph (B)(ii).

11          (D) ESTABLISHMENT OF PERIOD.—A  
12          qualified coverage period with respect to an in-  
13          dividual shall be established through presen-  
14          tation of certifications described in subsection  
15          (c) or in such other manner as may be specified  
16          in regulations to carry out this title.

17          (c) CERTIFICATIONS OF COVERAGE; CONFORMING  
18          COVERAGE.—

19          (1) IN GENERAL.—The plan administrator of a  
20          group health plan, or the insurer or HMO offering  
21          health insurance coverage in connection with a group  
22          health plan, shall, on request made on behalf of an  
23          individual covered (or previously covered within the  
24          previous 18 months) under the plan or coverage,  
25          provide for a certification of the period of coverage

1 of the individual under such plan or coverage and of  
2 the waiting period (if any) imposed with respect to  
3 the individual for any coverage under the plan.

4 (2) STANDARD METHOD.—Subject to paragraph  
5 (3), a group health plan, or insurer or HMO offering  
6 health insurance coverage in connection with a group  
7 health plan, shall determine qualified coverage peri-  
8 ods under subsection (b)(3)(B) by including all peri-  
9 ods described in such subsection, without regard to  
10 the specific benefits offered during such a period.

11 (3) ALTERNATIVE METHOD.—Such a plan, in-  
12 surer, or HMO may elect to make such determina-  
13 tion on a benefit-specific basis for all participants  
14 and beneficiaries and not to include as a qualified  
15 coverage period with respect to a specific benefit  
16 coverage during a previous period unless such pre-  
17 vious coverage for that benefit was included at the  
18 end of the most recent period of coverage. In the  
19 case of such an election—

20 (A) the plan, insurer, or HMO shall promi-  
21 nently state in any disclosure statements con-  
22 cerning the plan or coverage and to each en-  
23 rollee at the time of enrollment under the plan  
24 (or at the time the health insurance coverage is  
25 offered for sale in the group health market)

1           that the plan or coverage has made such elec-  
 2           tion and shall include a description of the effect  
 3           of this election; and

4                   (B) upon the request of the plan, insurer,  
 5           or HMO, the entity providing a certification  
 6           under paragraph (1)—

7                           (i) shall promptly disclose to the re-  
 8                           questing plan, insurer, or HMO the plan  
 9                           statement (insofar as it relates to health  
 10                          benefits under the plan) or other detailed  
 11                          benefit information on the benefits avail-  
 12                          able under the previous plan or coverage,  
 13                          and

14                           (ii) may charge for the reasonable  
 15                          cost of providing such information.

16 **SEC. 102. LIMITATION ON PREEXISTING CONDITION EXCLU-**  
 17 **SIONS; NO APPLICATION TO CERTAIN**  
 18 **NEWBORNS, ADOPTED CHILDREN, AND PREG-**  
 19 **NANCY.**

20           (a) LIMITATION OF PERIOD.—

21                   (1) IN GENERAL.—Subject to the succeeding  
 22           provisions of this section, a group health plan, and  
 23           an insurer or HMO offering health insurance cov-  
 24           erage in connection with a group health plan, shall  
 25           provide that any preexisting condition limitation pe-

1       riod (as defined in section 101(b)(2)) does not ex-  
2       ceed 12 months, counting from the effective date of  
3       coverage.

4           (2) EXTENSION OF PERIOD IN THE CASE OF  
5       LATE ENROLLMENT.—In the case of a participant or  
6       beneficiary whose initial coverage commences after  
7       the date the participant or beneficiary first becomes  
8       eligible for coverage under the group health plan,  
9       the reference in paragraph (1) to “12 months” is  
10      deemed a reference to “18 months”.

11      (b) EXCLUSION NOT APPLICABLE TO CERTAIN  
12      NEWBORNS AND CERTAIN ADOPTIONS.—

13           (1) IN GENERAL.—Subject to paragraph (2), a  
14      group health plan, and an insurer or HMO offering  
15      health insurance coverage in connection with a group  
16      health plan, may not provide any limitation on bene-  
17      fits based on the existence of a preexisting condition  
18      in the case of—

19           (A) an individual who within the 30-day  
20      period beginning with the date of birth, or

21           (B) an adopted child or a child placed for  
22      adoption beginning at the time of adoption or  
23      placement if the individual, within the 30-day  
24      period beginning on the date of adoption or  
25      placement,

1 becomes covered under a group health plan or other-  
2 wise becomes covered under health insurance cov-  
3 erage (or covered for medical assistance under title  
4 XIX of the Social Security Act).

5 (2) LOSS IF BREAK IN COVERAGE.—Paragraph  
6 (1) shall no longer apply to an individual if the indi-  
7 vidual does not have any coverage described in sec-  
8 tion 101(b)(3)(B)(i) for a continuous period of 60  
9 days, not counting in such period any days that are  
10 in a waiting period for any coverage under a group  
11 health plan.

12 (3) PLACED FOR ADOPTION DEFINED.—In this  
13 subsection and section 103(e), the term “place-  
14 ment”, or being “placed”, for adoption, in connec-  
15 tion with any placement for adoption of a child with  
16 any person, means the assumption and retention by  
17 such person of a legal obligation for total or partial  
18 support of such child in anticipation of adoption of  
19 such child. The child’s placement with such person  
20 terminates upon the termination of such legal obliga-  
21 tion.

22 (c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—  
23 For purposes of this section, pregnancy shall not be treat-  
24 ed as a preexisting condition.

1 (d) ELIGIBILITY PERIOD IMPOSED BY HEALTH  
2 MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO  
3 PREEXISTING CONDITION LIMITATION.—A health mainte-  
4 nance organization which offers health insurance coverage  
5 in connection with a group health plan and which does  
6 not use the preexisting condition limitations allowed under  
7 this section and section 101 with respect to any particular  
8 coverage option may impose an eligibility period for such  
9 coverage option, but only if such period does not exceed—

10 (1) 60 days, in the case of a participant or ben-  
11 eficiary whose initial coverage commences at the  
12 time such participant or beneficiary first becomes el-  
13 igible for coverage under the plan, or

14 (2) 90 days, in the case of a participant or ben-  
15 eficiary whose initial coverage commences after the  
16 date on which such participant or beneficiary first  
17 becomes eligible for coverage.

18 Such an HMO may use alternative methods, from those  
19 described in the previous sentence, to address adverse se-  
20 lection as approved by the applicable State authority. For  
21 purposes of this subsection, the term “eligibility period”  
22 means a period which, under the terms of the health insur-  
23 ance coverage offered by the health maintenance organiza-  
24 tion, must expire before the health insurance coverage be-  
25 comes effective. Any such eligibility period shall be treated



1 for purposes of this subtitle as a waiting period under the  
2 plan and shall run concurrently with any other applicable  
3 waiting period under the plan.

4 **SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH**  
5 **STATUS AND PROVIDING FOR ENROLLMENT**  
6 **PERIODS.**

7 (a) PROHIBITION OF EXCLUSION OF PARTICIPANTS  
8 OR BENEFICIARIES BASED ON HEALTH STATUS.—

9 (1) IN GENERAL.—A group health plan, and an  
10 insurer or HMO offering health insurance coverage  
11 in connection with a group health plan, may not ex-  
12 clude an employee or his or her beneficiary from  
13 being (or continuing to be) enrolled as a participant  
14 or beneficiary under the terms of such plan or cov-  
15 erage based on health status (as defined in section  
16 191(c)(6)).

17 (2) CONSTRUCTION.—Nothing in this sub-  
18 section shall be construed as preventing the estab-  
19 lishment of preexisting condition limitations and re-  
20 strictions to the extent consistent with the provisions  
21 of this subtitle.

22 (b) PROHIBITION OF DISCRIMINATION IN PREMIUM  
23 CONTRIBUTIONS OF INDIVIDUAL PARTICIPANTS OR  
24 BENEFICIARIES BASED ON HEALTH STATUS.—

1           (1) IN GENERAL.—A group health plan, and an  
2 insurer or HMO offering health insurance coverage  
3 in connection with a group health plan, may not re-  
4 quire a participant or beneficiary to pay a premium  
5 or contribution which is greater than such premium  
6 or contribution for a similarly situated participant or  
7 beneficiary solely on the basis of the health status  
8 of the participant or beneficiary.

9           (2) CONSTRUCTION.—Nothing in this sub-  
10 section is intended—

11               (A) to effect the premium rates an insurer  
12 or HMO may charge an employer for health in-  
13 surance coverage provided in connection a  
14 group health plan,

15               (B) to prevent a group health plan (or in-  
16 surer or HMO in health insurance coverage of-  
17 fered in connection with such a plan) from es-  
18 tablishing premium discounts or modifying oth-  
19 erwise applicable copayments or deductibles in  
20 return for adherence to programs of health pro-  
21 motion and disease prevention, or

22               (C) to prevent such a plan, insurer, or  
23 HMO from varying the premiums or contribu-  
24 tions required of participants or beneficiaries  
25 based on factors (such as scope of benefits, geo-

1           graphic area of residence, or wage levels) that  
2           are not directly related to health status.

3           (c) ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO  
4 LOSE OTHER COVERAGE.—A group health plan shall per-  
5 mit an uncovered employee who is otherwise eligible for  
6 coverage under the terms of the plan (or an uncovered  
7 dependent, as defined under the terms of the plan, of such  
8 an employee, if family coverage is available) to enroll for  
9 coverage under the plan under at least one benefit option  
10 if each of the following conditions is met:

11           (1) The employee or dependent was covered  
12           under a group health plan or had health insurance  
13           coverage at the time coverage was previously offered  
14           to the employee or individual.

15           (2) The employee stated in writing at such time  
16           that coverage under a group health plan or health  
17           insurance coverage was the reason for declining en-  
18           rollment.

19           (3) The employee or dependent lost coverage  
20           under a group health plan or health insurance cov-  
21           erage (as a result of loss of eligibility for the cov-  
22           erage, termination of employment, or reduction in  
23           the number of hours of employment).

1           (4) The employee requests such enrollment  
2       within 30 days after the date of termination of such  
3       coverage.

4       (d) DEPENDENT BENEFICIARIES.—

5           (1) IN GENERAL.—If a group health plan  
6       makes family coverage available, the plan may not  
7       require, as a condition of coverage of an individual  
8       as a dependent (as defined under the terms of the  
9       plan) of a participant in the plan, a waiting period  
10      applicable to the coverage of a dependent who—

11           (A) is a newborn,

12           (B) is an adopted child or child placed for  
13      adoption (within the meaning of section  
14      102(b)(3)), at the time of adoption or place-  
15      ment, or

16           (C) is a spouse, at the time of marriage,  
17      if the participant has met any waiting period appli-  
18      cable to that participant.

19       (2) TIMELY ENROLLMENT.—

20           (A) IN GENERAL.—Enrollment of a partici-  
21      pant's beneficiary described in paragraph (1)  
22      shall be considered to be timely if a request for  
23      enrollment is made within 30 days of the date  
24      family coverage is first made available or, in the  
25      case described in—

1 (i) paragraph (1)(A), within 30 days  
 2 of the date of the birth,

3 (ii) paragraph (1)(B), within 30 days  
 4 of the date of the adoption or placement  
 5 for adoption, or

6 (iii) paragraph (1)(C), within 30 days  
 7 of the date of the marriage with such a  
 8 beneficiary who is the spouse of the partic-  
 9 ipant,  
 10 if family coverage is available as of such date.

11 (B) COVERAGE.—If available coverage in-  
 12 cludes family coverage and enrollment is made  
 13 under such coverage on a timely basis under  
 14 subparagraph (A), the coverage shall become ef-  
 15 fective not later than the first day of the first  
 16 month beginning 15 days after the date the  
 17 completed request for enrollment is received.

18 (e) MULTIEMPLOYER PLANS, MULTIPLE EMPLOYER  
 19 HEALTH PLANS, AND MULTIPLE EMPLOYER WELFARE  
 20 ARRANGEMENTS.—A group health plan which is a multi-  
 21 employer plan, a multiple employer health plan (as de-  
 22 fined in section 701(4) of the Employee Retirement In-  
 23 come Security Act of 1974), or a multiple employer wel-  
 24 fare arrangement (to the extent to which benefits under  
 25 the arrangement consist of medical care) may not deny

1 an employer whose employees are covered under such a  
2 plan or arrangement continued access to the same or dif-  
3 ferent coverage under the terms of such a plan or ar-  
4 rangement, other than—

5 (1) for nonpayment of contributions,

6 (2) for fraud or other intentional misrepresen-  
7 tation of material fact by the employer,

8 (3) for noncompliance with material plan or ar-  
9 rangement provisions,

10 (4) because the plan or arrangement is ceasing  
11 to offer any coverage in a geographic area,

12 (5) for failure to meet the terms of an applica-  
13 ble collective bargaining agreement, to renew a col-  
14 lective bargaining or other agreement requiring or  
15 authorizing contributions to the plan, or to employ  
16 employees covered by such an agreement,

17 (6) in the case of a plan or arrangement to  
18 which subparagraph (C), (D), or (E) of section  
19 3(40) of the Employee Retirement Income Security  
20 Act of 1974 applies, to the extent necessary to meet  
21 the requirements of such subparagraph, or

22 (7) in the case of a multiple employer health  
23 plan (as defined in section 701(4) of such Act), for  
24 failure to meet the requirements under part 7 of

1 subtitle B of title I of such Act for exemption under  
 2 section 514(b)(6)(B) of such Act.

3 **SEC. 104. ENFORCEMENT.**

4 (a) ENFORCEMENT THROUGH COBRA PROVISIONS  
 5 IN INTERNAL REVENUE CODE.—

6 (1) APPLICATION OF COBRA SANCTIONS.—Sub-  
 7 section (a) of section 4980B of the Internal Revenue  
 8 Code of 1986 is amended by striking “the require-  
 9 ments of” and all that follows and inserting “the re-  
 10 quirements of—

11 “(1) subsection (f) with respect to any qualified  
 12 beneficiary, or

13 “(2) subject to subsection (h)—

14 “(A) section 101 or 102 of the Health  
 15 Coverage Availability and Affordability Act of  
 16 1996 with respect to any individual covered  
 17 under the group health plan, or

18 “(B) section 103 (other than subsection  
 19 (e)) of such Act with respect to any individ-  
 20 ual.”.

21 (2) NOTICE REQUIREMENT.—Section  
 22 4980B(f)(6)(A) of such Code is amended by insert-  
 23 ing before the period the following: “and subtitle A  
 24 of title I of the Health Coverage Availability and Af-  
 25 fordability Act of 1996”.

1           (3) SPECIAL RULES.—Section 4980B of such  
2       Code is amended by adding at the end the following:

3       “(h) SPECIAL RULES.—For purposes of applying this  
4       section in the case of requirements described in subsection  
5       (a)(2) relating to section 101, section 102, or section 103  
6       (other than subsection (e)) of the Health Coverage Avail-  
7       ability and Affordability Act of 1996—

8           “(1) IN GENERAL.—

9           “(A) DEFINITION OF GROUP HEALTH  
10       PLAN.—The term ‘group health plan’ has the  
11       meaning given such term in section 191(a) of  
12       the Health Coverage Availability and Afford-  
13       ability Act of 1996.

14          “(B) QUALIFIED BENEFICIARY.—Sub-  
15       sections (b), (c), and (e) shall be applied by  
16       substituting the term ‘individual’ for the term  
17       ‘qualified beneficiary’ each place it appears.

18          “(C) NONCOMPLIANCE PERIOD.—Clause  
19       (ii) of subsection (b)(2)(B) and the second sen-  
20       tence of subsection (b)(2) shall not apply.

21          “(D) LIMITATION ON TAX.—Subparagraph  
22       (B) of subsection (c)(3) shall not apply.

23          “(E) LIABILITY FOR TAX.—Paragraph (2)  
24       of subsection (e) shall not apply.



1           “(2) DEFERRAL TO STATE REGULATION.—No  
2       tax shall be imposed by this section on any failure  
3       to meet the requirements of such section by any en-  
4       tity which offers health insurance coverage and  
5       which is an insurer or health maintenance organiza-  
6       tion (as defined in section 191(c) of the Health Cov-  
7       erage Availability and Affordability Act of 1996)  
8       regulated by a State unless the Secretary of Health  
9       and Human Services has made the determination  
10      described in section 104(c)(2) of such Act with re-  
11      spect to such State, section, and entity.

12           “(3) LIMITATION FOR INSURED PLANS.—In the  
13      case of a group health plan of a small employer (as  
14      defined in section 191 of the Health Coverage Avail-  
15      ability and Affordability Act of 1996) that provides  
16      health care benefits solely through a contract with  
17      an insurer or health maintenance organization (as  
18      defined in such section), no tax shall be imposed by  
19      this section upon the employer on a failure to meet  
20      such requirements if the failure is solely because of  
21      the product offered by the insurer or organization  
22      under such contract.

23           “(4) LIMITATION ON IMPOSITION OF TAX.—In  
24      no case shall a tax be imposed by this section for a  
25      failure to meet such a requirement if—

1           “(A) a civil money penalty has been im-  
2           posed by the Secretary of Labor under part 5  
3           of subtitle A of title I of the Employee Retirement  
4           Income Security Act of 1974 with respect  
5           to such failure, or

6           “(B) a civil money penalty has been im-  
7           posed by the Secretary of Health and Human  
8           Services under section 104(c) of the Health  
9           Coverage Availability and Affordability Act of  
10          1996 with respect to such failure.”.

11          (b) ENFORCEMENT THROUGH ERISA SANCTIONS  
12          FOR CERTAIN GROUP HEALTH PLANS.—

13               (1) IN GENERAL.—Subject to the succeeding  
14               provisions of this subsection, sections 101 through  
15               103 of this subtitle (and subtitle D insofar as it is  
16               applicable to such sections) shall be deemed to be  
17               provisions of title I of the Employee Retirement In-  
18               come Security Act of 1974 for purposes of applying  
19               such title.

20               (2) FEDERAL ENFORCEMENT ONLY IF NO EN-  
21               FORCEMENT THROUGH STATE.—The Secretary of  
22               Labor shall enforce each section referred to in para-  
23               graph (1) with respect to any entity which is an in-  
24               surer or health maintenance organization regulated  
25               by a State only if the Secretary of Labor determines

1       that such State has not provided for enforcement of  
2       State laws which govern the same matters as are  
3       governed by such section and which require compli-  
4       ance by such entity with at least the same require-  
5       ments as those provided under such section.

6           (3) LIMITATIONS ON LIABILITY.—

7               (A) NO APPLICATION WHERE FAILURE  
8       NOT DISCOVERED EXERCISING REASONABLE  
9       DILIGENCE.—No liability shall be imposed  
10      under this subsection on the basis of any failure  
11      during any period for which it is established to  
12      the satisfaction of the Secretary of Labor that  
13      none of the persons against whom the liability  
14      would be imposed knew, or exercising reason-  
15      able diligence would have known, that such fail-  
16      ure existed.

17            (B) NO APPLICATION WHERE FAILURE  
18      CORRECTED WITHIN 30 DAYS.—No liability  
19      shall be imposed under this subsection on the  
20      basis of any failure if such failure was due to  
21      reasonable cause and not to willful neglect, and  
22      such failure is corrected during the 30-day pe-  
23      riod beginning on the first day any of the per-  
24      sons against whom the liability would be im-

1           posed knew, or exercising reasonable diligence  
2           would have known, that such failure existed.

3           (4) AVOIDING DUPLICATION OF CERTAIN PEN-  
4           ALTIES.—In no case shall a civil money penalty be  
5           imposed under the authority provided under para-  
6           graph (1) for a violation of this subtitle for which  
7           an excise tax has been imposed under section 4980B  
8           of the Internal Revenue Code of 1986 or a civil  
9           money penalty imposed under subsection (c).

10          (c) ENFORCEMENT THROUGH CIVIL MONEY PEN-  
11          ALTIES.—

12               (1) IMPOSITION.—

13                   (A) IN GENERAL.—Subject to the succeed-  
14                   ing provisions of this subsection, any group  
15                   health plan, insurer, or organization that fails  
16                   to meet a requirement of this subtitle (other  
17                   than section 103(e)) is subject to a civil money  
18                   penalty under this section.

19                   (B) LIABILITY FOR PENALTY.—Rules simi-  
20                   lar to the rules described in section 4980B(e) of  
21                   the Internal Revenue Code of 1986 for liability  
22                   for a tax imposed under section 4980B(a) of  
23                   such Code shall apply to liability for a penalty  
24                   imposed under subparagraph (A).

25                   (C) AMOUNT OF PENALTY.—

1 (i) IN GENERAL.—The maximum  
2 amount of penalty imposed under this  
3 paragraph is \$100 for each day for each  
4 individual with respect to which such a  
5 failure occurs.

6 (ii) CONSIDERATIONS IN IMPOSI-  
7 TION.—In determining the amount of any  
8 penalty to be assessed under this para-  
9 graph, the Secretary of Health and Human  
10 Services shall take into account the pre-  
11 vious record of compliance of the person  
12 being assessed with the applicable require-  
13 ments of this subtitle, the gravity of the  
14 violation, and the overall limitations for  
15 unintentional failures provided under sec-  
16 tion 4980B(c)(4) of the Internal Revenue  
17 Code of 1986.

18 (iii) LIMITATIONS.—

19 (I) PENALTY NOT TO APPLY  
20 WHERE FAILURE NOT DISCOVERED  
21 EXERCISING REASONABLE DILI-  
22 GENCE.—No civil money penalty shall  
23 be imposed under this paragraph on  
24 any failure during any period for  
25 which it is established to the satisfac-

tion of the Secretary that none of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(D) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision

1 shall be made on the record pursuant to  
2 section 554 of title 5, United States Code.  
3 If no hearing is requested, the assessment  
4 shall constitute a final and unappealable  
5 order.

6 (ii) HEARING PROCEDURE.—If a  
7 hearing is requested, the initial agency de-  
8 cision shall be made by an administrative  
9 law judge, and such decision shall become  
10 the final order unless the Secretary modi-  
11 fies or vacates the decision. Notice of in-  
12 tent to modify or vacate the decision of the  
13 administrative law judge shall be issued to  
14 the parties within 30 days after the date of  
15 the decision of the judge. A final order  
16 which takes effect under this paragraph  
17 shall be subject to review only as provided  
18 under subparagraph (D).

19 (E) JUDICIAL REVIEW.—

20 (i) FILING OF ACTION FOR REVIEW.—  
21 Any person against whom an order impos-  
22 ing a civil money penalty has been entered  
23 after an agency hearing under this para-  
24 graph may obtain review by the United  
25 States district court for any district in

1           which such person is located or the United  
2           States District Court for the District of  
3           Columbia by filing a notice of appeal in  
4           such court within 30 days from the date of  
5           such order, and simultaneously sending a  
6           copy of such notice be registered mail to  
7           the Secretary.

8           (ii) CERTIFICATION OF ADMINISTRATIVE  
9           RECORD.—The Secretary shall  
10          promptly certify and file in such court the  
11          record upon which the penalty was im-  
12          posed.

13          (iii) STANDARD FOR REVIEW.—The  
14          findings of the Secretary shall be set aside  
15          only if found to be unsupported by sub-  
16          stantial evidence as provided by section  
17          706(2)(E) of title 5, United States Code.

18          (iv) APPEAL.—Any final decision,  
19          order, or judgment of such district court  
20          concerning such review shall be subject to  
21          appeal as provided in chapter 83 of title 28  
22          of such Code.

23          (F) FAILURE TO PAY ASSESSMENT; MAIN-  
24          TENANCE OF ACTION.—



1 (i) FAILURE TO PAY ASSESSMENT.—If  
2 any person fails to pay an assessment after  
3 it has become a final and unappealable  
4 order, or after the court has entered final  
5 judgment in favor of the Secretary, the  
6 Secretary shall refer the matter to the At-  
7 torney General who shall recover the  
8 amount assessed by action in the appro-  
9 priate United States district court.

10 (ii) NONREVIEWABILITY.—In such ac-  
11 tion the validity and appropriateness of the  
12 final order imposing the penalty shall not  
13 be subject to review.

14 (G) PAYMENT OF PENALTIES.—Except as  
15 otherwise provided, penalties collected under  
16 this paragraph shall be paid to the Secretary  
17 (or other officer) imposing the penalty and shall  
18 be available without appropriation and until ex-  
19 pended for the purpose of enforcing the provi-  
20 sions with respect to which the penalty was im-  
21 posed.

22 (2) FEDERAL ENFORCEMENT ONLY IF NO EN-  
23 FORCEMENT THROUGH STATE.—Paragraph (1) shall  
24 apply to enforcement of the requirements of section  
25 101, 102, or 103 (other than section 103(e)) with

1       respect to any entity which offers health insurance  
2       coverage and which is an insurer or HMO regulated  
3       by a State only if the Secretary of Health and  
4       Human Services has determined that such State has  
5       not provided for enforcement of State laws which  
6       govern the same matters as are governed by such  
7       section and which require compliance by such entity  
8       with at least the same requirements as those pro-  
9       vided under such section.

10           (3) NONDUPLICATION OF SANCTIONS.—In no  
11       case shall a civil money penalty be imposed under  
12       this subsection for a violation of this subtitle for  
13       which an excise tax has been imposed under section  
14       4980B of the Internal Revenue Code of 1986 or for  
15       which a civil money penalty has been imposed under  
16       the authority provided under subsection (b).

17           (d) COORDINATION IN ADMINISTRATION.—The Sec-  
18       retaries of the Treasury, Labor, and Health and Human  
19       Services shall issue regulations that are nonduplicative to  
20       carry out this subtitle. Such regulations shall be issued  
21       in a manner that assures coordination and nonduplication  
22       in their activities under this subtitle.

1 **Subtitle B—Certain Requirements**  
 2 **for Insurers and HMOs in the**  
 3 **Group and Individual Markets**

4 **PART 1—AVAILABILITY OF GROUP HEALTH**  
 5 **INSURANCE COVERAGE**

6 **SEC. 131. GUARANTEED AVAILABILITY OF GENERAL COV-**  
 7 **ERAGE IN THE SMALL GROUP MARKET.**

8 (a) ISSUANCE OF COVERAGE.—

9 (1) IN GENERAL.—Subject to the succeeding  
 10 subsections of this section, each insurer or HMO  
 11 that offers health insurance coverage in the small  
 12 group market in a State—

13 (A) must accept every small employer in  
 14 the State that applies for such coverage; and

15 (B) must accept for enrollment under such  
 16 coverage every eligible individual (as defined in  
 17 paragraph (2)) who applies for enrollment dur-  
 18 ing the initial period in which the individual  
 19 first becomes eligible for coverage under the  
 20 group health plan and may not place any re-  
 21 striction which is inconsistent with section  
 22 103(a) on an individual being a participant or  
 23 beneficiary so long as such individual is an eli-  
 24 gible individual.

1           (2) ELIGIBLE INDIVIDUAL DEFINED.—In this  
2           section, the term “eligible individual” means, with  
3           respect to an insurer or HMO that offers health in-  
4           surance coverage to any small employer in the small  
5           group market, such an individual in relation to the  
6           employer as shall be determined—

7                   (A) in accordance with the terms of such  
8           plan,

9                   (B) as provided by the insurer or HMO  
10           under rules of the insurer or HMO which are  
11           uniformly applicable, and

12                   (C) in accordance with all applicable State  
13           laws governing such insurer or HMO.

14       (b) SPECIAL RULES FOR NETWORK PLANS AND  
15       HMOs.—

16           (1) IN GENERAL.—In the case of an insurer  
17           that offers health insurance coverage in the small  
18           group market through a network plan and in the  
19           case of an HMO that offers health insurance cov-  
20           erage in connection with such a plan, the insurer or  
21           HMO may—

22                   (A) limit the employers that may apply for  
23           such coverage to those with eligible individuals  
24           whose place of employment or residence is in  
25           the service area for such plan or HMO;

1 (B) limit the individuals who may be en-  
2 rolled under such coverage to those whose place  
3 of residence or employment is within the service  
4 area for such plan or HMO; and

5 (C) within the service area of such plan or  
6 HMO, deny such coverage to such employers if  
7 the insurer or HMO demonstrates that—

8 (i) it will not have the capacity to de-  
9 liver services adequately to enrollees of any  
10 additional groups because of its obligations  
11 to existing group contract holders and en-  
12 rollees, and

13 (ii) it is applying this paragraph uni-  
14 formly to all employers without regard to  
15 the claims experience of those employers  
16 and their employees (and their bene-  
17 ficiaries) or the health status of such em-  
18 ployees and beneficiaries.

19 (2) 180-DAY SUSPENSION UPON DENIAL OF  
20 COVERAGE.—An insurer or HMO, upon denying  
21 health insurance coverage in any service area in ac-  
22 cordance with paragraph (1)(C), may not offer cov-  
23 erage in the small group market within such service  
24 area for a period of 180 days after such coverage is  
25 denied.

1       (c) SPECIAL RULE FOR FINANCIAL CAPACITY LIM-  
2 ITS.—

3           (1) IN GENERAL.—An insurer or HMO may  
4 deny health insurance coverage in the small group  
5 market if the insurer or HMO demonstrates to the  
6 applicable State authority that—

7           (A) it does not have the financial reserves  
8 necessary to underwrite additional coverage,  
9 and

10          (B) it is applying this paragraph uniformly  
11 to all employers without regard to the claims  
12 experience or duration of coverage of those em-  
13 ployers and their employees (and their bene-  
14 ficiaries) or the health status of such employees  
15 and beneficiaries.

16          (2) 180-DAY SUSPENSION UPON DENIAL OF  
17 COVERAGE.—An insurer or HMO upon denying  
18 health insurance coverage in connection with group  
19 health plans in any service area in accordance with  
20 paragraph (1) may not offer coverage in connection  
21 with group health plans in the small group market  
22 within such service area for a period of 180 days  
23 after such coverage is denied.

24       (d) EXCEPTION TO REQUIREMENT FOR ISSUANCE OF  
25 COVERAGE BY REASON OF FAILURE BY PLAN TO MEET

1 CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION  
2 RULES.—

3 (1) IN GENERAL.—Subsection (a) shall not  
4 apply in the case of any group health plan with re-  
5 spect to which—

6 (A) participation rules of an insurer or  
7 HMO which are described in paragraph (2) are  
8 not met, or

9 (B) contribution rules of an insurer or  
10 HMO which are described in paragraph (3) are  
11 not met.

12 (2) PARTICIPATION RULES.—For purposes of  
13 paragraph (1)(A), participation rules (if any) of an  
14 insurer or HMO shall be treated as met with respect  
15 to a group health plan only if such rules are uni-  
16 formly applicable and in accordance with applicable  
17 State law and the number or percentage of eligible  
18 individuals who, under the plan, are participants or  
19 beneficiaries equals or exceeds a level which is deter-  
20 mined in accordance with such rules.

21 (3) CONTRIBUTION RULES.—For purposes of  
22 paragraph (1)(B), contribution rules (if any) of an  
23 insurer or HMO shall be treated as met with respect  
24 to a group health plan only if such rules are in ac-  
25 cordance with applicable State law.

1 **SEC. 132. GUARANTEED RENEWABILITY OF GROUP COV-**  
2 **ERAGE.**

3 (a) IN GENERAL.—Except as provided in this section,  
4 if an insurer or health maintenance organization offers  
5 health insurance coverage in the small or large group mar-  
6 ket, the insurer or organization must renew or continue  
7 in force such coverage at the option of the employer.

8 (b) GENERAL EXCEPTIONS.—An insurer or organiza-  
9 tion may nonrenew or discontinue health insurance cov-  
10 erage offered an employer based only on one or more of  
11 the following:

12 (1) NONPAYMENT OF PREMIUMS.—The em-  
13 ployer has failed to pay premiums or contributions  
14 in accordance with the terms of the health insurance  
15 coverage or the insurer or organization has not re-  
16 ceived timely premium payments.

17 (2) FRAUD.—The employer has performed an  
18 act or practice that constitutes fraud or made an in-  
19 tentional misrepresentation of material fact under  
20 the terms of the coverage.

21 (3) VIOLATION WITH PARTICIPATION OR CON-  
22 TRIBUTION RULES.—The employer has failed to  
23 comply with a material plan provision relating to  
24 participation or contribution rules in accordance  
25 with section 131(d).



1           (4) TERMINATION OF PLAN.—Subject to sub-  
2       section (c), the insurer or organization is ceasing to  
3       offer coverage in the small or large group market in  
4       a State (or, in the case of a network plan or HMO,  
5       in a geographic area).

6           (5) MOVEMENT OUTSIDE SERVICE AREA.—The  
7       employer has changed the place of employment in  
8       such manner that employees and dependents reside  
9       and are employed outside the service area of the in-  
10      surer or organization or outside the area for which  
11      the insurer or organization is authorized to do busi-  
12      ness.

13 Paragraph (5) shall apply to an insurer or HMO only if  
14 it is applied uniformly without regard to the claims experi-  
15 ence of employers and their employees (and their bene-  
16 ficiaries) or the health status of such employees and bene-  
17 ficiaries.

18       (c) EXCEPTIONS FOR UNIFORM TERMINATION OF  
19 COVERAGE.—

20           (1) PARTICULAR TYPE OF COVERAGE NOT OF-  
21       FERED.—In any case in which a insurer or HMO  
22       decides to discontinue offering a particular type of  
23       health insurance coverage in the small or large  
24       group market, coverage of such type may be discon-  
25       tinued by the insurer or organization only if—

1 (A) the insurer or organization provides  
2 notice to each employer provided coverage of  
3 this type in such market (and participants and  
4 beneficiaries covered under such coverage) of  
5 such discontinuation at least 90 days prior to  
6 the date of the discontinuation of such cov-  
7 erage;

8 (B) the insurer or organization offers to  
9 each employer in the small employer or large  
10 employer market provided coverage of this type,  
11 the option to purchase any other health insur-  
12 ance coverage currently being offered by the in-  
13 surer or organization for employers in such  
14 market; and

15 (C) in exercising the option to discontinue  
16 coverage of this type and in offering one or  
17 more replacement coverage, the insurer or orga-  
18 nization acts uniformly without regard to the  
19 health status or insurability of participants or  
20 beneficiaries covered or new participants or  
21 beneficiaries who may become eligible for such  
22 coverage.

23 (2) DISCONTINUANCE OF ALL COVERAGE.—

24 (A) IN GENERAL.—Subject to subpara-  
25 graph (C), in any case in which an insurer or

1 HMO elects to discontinue offering all health  
2 insurance coverage in the small group market  
3 or the large group market, or both markets, in  
4 a State, health insurance coverage may be dis-  
5 continued by the insurer or organization only  
6 if—

7 (i) the insurer or organization pro-  
8 vides notice to the applicable State author-  
9 ity and to each employer (and participants  
10 and beneficiaries covered under such cov-  
11 erage) of such discontinuation at least 180  
12 days prior to the date of the expiration of  
13 such coverage, and

14 (ii) all health insurance issued or de-  
15 livered for issuance in the State in such  
16 market (or markets) are discontinued and  
17 coverage under such health insurance cov-  
18 erage in such market (or markets) is not  
19 renewed.

20 (B) PROHIBITION ON MARKET REENTRY.—

21 In the case of a discontinuation under subpara-  
22 graph (A) in one or both markets, the insurer  
23 or organization may not provide for the issu-  
24 ance of any health insurance coverage in the  
25 market and State involved during the 5-year pe-

1           riod beginning on the date of the discontinu-  
 2           ation of the last health insurance coverage not  
 3           so renewed.

4           (d) EXCEPTION FOR UNIFORM MODIFICATION OF  
 5 COVERAGE.—At the time of coverage renewal, an insurer  
 6 or HMO may modify the coverage offered to a group  
 7 health plan in the group health market so long as such  
 8 modification is effective on a uniform basis among group  
 9 health plans with that type of coverage.

10   **PART 2—AVAILABILITY OF INDIVIDUAL HEALTH**  
 11                           **INSURANCE COVERAGE**

12   **SEC. 141. GUARANTEED AVAILABILITY OF INDIVIDUAL**  
 13                           **HEALTH INSURANCE COVERAGE TO CERTAIN**  
 14                           **INDIVIDUALS WITH PRIOR GROUP COV-**  
 15                           **ERAGE.**

16           (a) GOALS.—The goals of this section are—

17                   (1) to guarantee that any qualifying individual  
 18                   (as defined in subsection (b)(1)) is able to obtain  
 19                   qualifying coverage (as defined in subsection (b)(2));  
 20                   and

21                   (2) to assure that qualifying individuals obtain-  
 22                   ing such coverage receive credit for their prior cov-  
 23                   erage toward the new coverage’s preexisting condi-  
 24                   tion exclusion period (if any) in a manner consistent  
 25                   with subsection (b)(3).

1 (b) QUALIFYING INDIVIDUAL AND HEALTH INSUR-  
2 ANCE COVERAGE DEFINED.—In this section—

3 (1) QUALIFYING INDIVIDUAL.—The term  
4 “qualifying individual” means an individual—

5 (A)(i) for whom, as of the date on which  
6 the individual seeks coverage under this section,  
7 the aggregate of the qualified coverage periods  
8 (as defined in section 101(b)(3)(B)) is 18 or  
9 more months and (ii) whose most recent prior  
10 coverage was under a group health plan, gov-  
11 ernmental plan, or church plan (or health insur-  
12 ance coverage offered in connection with any  
13 such plan);

14 (B) who is not eligible for coverage under  
15 (i) a group health plan, (ii) part A or part B  
16 of title XVIII of the Social Security Act, or (iii)  
17 a State plan under title XIX of such Act (or  
18 any successor program), and does not have in-  
19 dividual health insurance coverage;

20 (C) with respect to whom the most recent  
21 coverage within the coverage period described in  
22 subparagraph (A)(i) was not terminated based  
23 on a factor described in paragraph (1) or (2) of  
24 section 132(b);

1 (D) if the individual had been offered the  
 2 option of continuation coverage under a  
 3 COBRA continuation provision or under a simi-  
 4 lar State program, who elected such coverage;  
 5 and

6 (E) who, if the individual elected such con-  
 7 tinuation coverage, has exhausted such continu-  
 8 ation coverage.

9 In applying subparagraph (A)(i), the reference in  
 10 section 101(b)(3)(B)(ii) to a 60-day break in cov-  
 11 erage is deemed a reference to a 60-day break in  
 12 any coverage described in section 101(b)(3)(B)(i).

13 (2) QUALIFYING COVERAGE.—

14 (A) IN GENERAL.—The term “qualifying  
 15 coverage” means, with respect to an insurer or  
 16 HMO in relation to an qualifying individual, in-  
 17 dividual health insurance coverage for which the  
 18 actuarial value of the benefits is not less than—

19 (i) the weighted average actuarial  
 20 value of the benefits provided by all the in-  
 21 dividual health insurance coverage issued  
 22 by the insurer or HMO in the State during  
 23 the previous year (not including coverage  
 24 issued under this section), or

(ii) the weighted average of the actuarial value of the benefits provided by all the individual health insurance coverage issued by all insurers and HMOs in the State during the previous year (not including coverage issued under this section), as elected by the plan or by the State under subsection (c)(1).

(B) ASSUMPTIONS.—For purposes of subparagraph (A), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(3) CREDITING FOR PREVIOUS COVERAGE.—Crediting is consistent with this paragraph only if any preexisting condition exclusion period is reduced at least to the extent such a period would be reduced if the coverage under this section were under a group health plan to which section 101(a) applies. In carrying out this subsection, provisions similar to the provisions of section 101(c) shall apply.

(c) OPTIONAL STATE ESTABLISHMENT OF MECHANISMS TO ACHIEVE GOALS OF GUARANTEEING AVAILABILITY OF COVERAGE.—

1           (1) IN GENERAL.—Any State may establish, to  
2           the extent of the State’s authority, public or private  
3           mechanisms reasonably designed to meet the goals  
4           specified in subsection (a). If a State implements  
5           such a mechanism by the deadline specified in para-  
6           graph (4), the State may elect to have such mecha-  
7           nisms apply instead of having subsection (d)(3)  
8           apply in the State. An election under this paragraph  
9           shall be by notice from the chief executive officer of  
10          the State to the Secretary of Health and Human  
11          Services on a timely basis consistent with the dead-  
12          lines specified in paragraph (4). In establishing what  
13          is qualifying coverage under such a mechanism  
14          under this subsection, a State may exercise the elec-  
15          tion described in subsection (b)(2)(A) with respect to  
16          each insurer or HMO in the State (or on a collective  
17          basis after exercising such election for each such in-  
18          surer or HMO).

19          (2) TYPES OF MECHANISMS.—State mecha-  
20          nisms under this subsection may include one or  
21          more (or a combination) of the following:

22                 (A) Health insurance coverage pools or  
23                 programs authorized or established by the  
24                 State.

25                 (B) Mandatory group conversion policies.



1                   (C) Guaranteed issue of one or more plans  
 2                   of individual health insurance coverage to quali-  
 3                   fying individuals.

4                   (D) Open enrollment by one or more insur-  
 5                   ers or HMOs.

6                   The mechanisms described in the previous sentence  
 7                   are not an exclusive list of the mechanisms (or com-  
 8                   binations of mechanisms) that may be used under  
 9                   this subsection.

10                  (3) SAFE HARBOR FOR BENEFITS UNDER CUR-  
 11                  RENT RISK POOLS.—In the case of a State that has  
 12                  a health insurance coverage pool or risk pool in ef-  
 13                  fect on March 12, 1996, and that implements the  
 14                  mechanism described in paragraph (2)(A), the bene-  
 15                  fits under such mechanism (or benefits the actuarial  
 16                  value of which is not less than the actuarial value  
 17                  of such current benefits, using the assumptions de-  
 18                  scribed in subsection (b)(2)(B)) are deemed, for pur-  
 19                  poses of this section, to constitute qualified coverage.

20                  (4) DEADLINE FOR STATE IMPLEMENTATION.—

21                   (A) IN GENERAL.—Subject to subpara-  
 22                   graph (B), the deadline under this paragraph is  
 23                   July 1, 1997.

24                   (B) EXTENSION TO PERMIT LEGISLA-  
 25                   TION.—The deadline under this paragraph is

1 July 1, 1998, in the case of a State the legisla-  
2 ture of which does not have a regular legislative  
3 session at any time between January 1, 1997,  
4 and June 30, 1997.

5 (C) CONSTRUCTION.—Nothing in this sec-  
6 tion shall be construed as preventing a State  
7 from—

8 (i) implementing guaranteed availabil-  
9 ity mechanisms before the deadline,

10 (ii) continuing in effect mechanisms  
11 that are in effect before the date of the en-  
12 actment of this Act,

13 (iii) offering guaranteed availability of  
14 coverage that is not qualifying coverage, or

15 (iv) offering guaranteed availability of  
16 coverage to individuals who are not quali-  
17 fying individuals.

18 (d) FALLBACK PROVISIONS.—

19 (1) NO STATE ELECTION.—If a State has not  
20 provided notice to the Secretary of an election on a  
21 timely basis under subsection (c), the Secretary shall  
22 notify the State that paragraph (3) will be applied  
23 in the State.

24 (2) PRELIMINARY DETERMINATION AFTER  
25 STATE ELECTION.—If—

1 (A) a State has provided notice of an elec-  
2 tion on a timely basis under subsection (c), and

3 (B) the Secretary finds, after consultation  
4 with the chief executive officer of the State and  
5 the insurance commissioner or chief insurance  
6 regulatory official of the State, that such a  
7 mechanism (for which notice was provided) is  
8 not reasonably designed to meet the goals speci-  
9 fied in subsection (a),

10 the Secretary shall notify the State of such prelimi-  
11 nary determination, of the consequences under para-  
12 graph (3) of a failure to implement such a mecha-  
13 nism, and permit the State a reasonable opportunity  
14 in which to modify the mechanism (or to adopt an-  
15 other mechanism) that is reasonably designed to  
16 meet the goals specified in subsection (a). The Sec-  
17 retary shall not make such a determination on any  
18 basis other than the basis described in subparagraph  
19 (B). If, after providing such notice and opportunity,  
20 the Secretary finds that the State has not imple-  
21 mented such a mechanism, the Secretary shall notify  
22 the State that paragraph (3) will be applied in the  
23 State.

24 (3) DESCRIPTION OF FALLBACK MECHANISM.—

25 As provided under paragraphs (1) and (2) and sub-

1       ject to paragraph (5), each insurer or HMO in the  
2       State involved that issues individual health insurance  
3       coverage—

4               (A) shall offer qualifying health insurance  
5       coverage, in which qualifying individuals obtain-  
6       ing such coverage receive credit for their prior  
7       coverage toward the new coverage’s preexisting  
8       condition exclusion period (if any) in a manner  
9       consistent with subsection (b)(3), to each quali-  
10      fying individual in the State, and

11              (B) may not decline to issue such coverage  
12      to such an individual based on health status  
13      (except as permitted under paragraph (4)).

14              (4) APPLICATION OF NETWORK AND CAPACITY  
15      LIMITS.—Under regulations, the provisions of sub-  
16      sections (b) and (c) of section 131 shall apply to an  
17      individual in the individual health insurance market  
18      under this subsection in the same manner as they  
19      apply under section 131 to an employer in the small  
20      group market.

21              (5) TERMINATION OF FALLBACK MECHANISM.—  
22      The provisions of this subsection shall cease to apply  
23      to a State if the Secretary finds that a State has im-  
24      plemented a mechanism that is reasonably designed  
25      to meet the goals specified in subsection (a), and

1       until the Secretary finds that such mechanism is no  
2       longer being implemented.

3       (e) CONSTRUCTION.—

4           (1) PREMIUMS.—Nothing in this section shall  
5       be construed to affect the determination of an in-  
6       surer or HMO as to the amount of the premium  
7       payable under an individual health insurance cov-  
8       erage under applicable state law.

9           (2) MARKET REQUIREMENTS.—

10           (A) IN GENERAL.—The provisions of sub-  
11       section (a) shall not be construed to require  
12       that an insurer or HMO offering health insur-  
13       ance coverage only in connection with a group  
14       health plan or an association offer individual  
15       health insurance coverage.

16           (B) CONVERSION POLICIES.—An insurer  
17       or HMO offering health insurance coverage in  
18       connection with a group health plan under sub-  
19       title A shall not be deemed to be an insurer or  
20       HMO offering an individual health insurance  
21       coverage solely because such insurer or HMO  
22       offers a conversion policy.

23           (3) DISREGARD OF ASSOCIATION COVERAGE.—  
24       An insurer or HMO that offers health insurance cov-  
25       erage only in connection with a group health plan or

1 in connection with individuals based on affiliation  
 2 with one or more bona fide associations is not con-  
 3 sidered, for purposes of this subtitle, to be offering  
 4 individual health insurance coverage.

5 (4) MARKETING OF PLANS.—Nothing in this  
 6 section shall be construed to prevent a State from  
 7 requiring insurer or HMOs offering individual health  
 8 insurance coverage to actively market such coverage.

9 **SEC. 142. GUARANTEED RENEWABILITY OF INDIVIDUAL**  
 10 **HEALTH INSURANCE COVERAGE.**

11 (a) GUARANTEED RENEWABILITY.—Subject to the  
 12 succeeding provisions of this section, an insurer or HMO  
 13 that provides individual health insurance coverage to an  
 14 individual shall renew or continue such coverage at the  
 15 option of the individual.

16 (b) NONRENEWAL PERMITTED IN CERTAIN CASES.—  
 17 An insurer or HMO may nonrenew or discontinue individ-  
 18 ual health insurance coverage of an individual only based  
 19 on one or more of the following:

20 (1) NONPAYMENT.—The individual fails to pay  
 21 payment of premiums or contributions in accordance  
 22 with the terms of the coverage or the insurer or or-  
 23 ganization has not failed to receive timely premium  
 24 payments.

1           (2) FRAUD.—The individual has performed an  
2           act or practice that constitutes fraud or made an in-  
3           tentional misrepresentation of material fact under  
4           the terms of the coverage.

5           (3) TERMINATION OF COVERAGE.—Subject to  
6           subsection (c), the insurer or HMO is ceasing to  
7           offer health insurance coverage in the individual  
8           market in a State (or, in the case of a network plan  
9           or HMO, in a geographic area).

10          (4) MOVEMENT OUTSIDE SERVICE AREA.—The  
11          individual has changed residence and resides outside  
12          the service area of the insurer or organization or  
13          outside the area for which the insurer or organiza-  
14          tion is authorized to do business.

15          Paragraph (4) shall apply to an insurer or HMO only if  
16          it is applied uniformly without regard to the claims experi-  
17          ence of employers and their employees (and their bene-  
18          ficiaries) or the health status of such employees and bene-  
19          ficiaries.

20          (c) TERMINATION OF INDIVIDUAL COVERAGE.—The  
21          provisions of section 132(c) shall apply to this section in  
22          the same manner as they apply under section 132, except  
23          that any reference to an employer or market is deemed  
24          a reference to the covered individual or the individual mar-  
25          ket, respectively.

1 (d) EXCEPTION FOR UNIFORM MODIFICATION OF  
2 COVERAGE.—The provisions of section 132(d) shall apply  
3 to individual health insurance coverage in the individual  
4 market under this section in the same manner as it applies  
5 to health insurance coverage offered in connection with a  
6 group health plan in the group market under such section.

7 **PART 3—ENFORCEMENT**

8 **SEC. 151. INCORPORATION OF PROVISIONS FOR STATE EN-**  
9 **FORCEMENT WITH FEDERAL FALLBACK AU-**  
10 **THORITY.**

11 The provisions of paragraphs (1) and (2) of section  
12 104(c) shall apply to enforcement of requirements in each  
13 section in part 1 or part 2 with respect to insurers and  
14 HMOs regulated by a State in the same manner as such  
15 provisions apply to enforcement of requirements in section  
16 101, 102, or 103 with respect to insurers and HMOs regu-  
17 lated by a State.



1 **Subtitle C—Affordable and Avail-**  
 2 **able Health Coverage Through**  
 3 **Multiple Employer Pooling Ar-**  
 4 **rangements**

5 **SEC. 161. CLARIFICATION OF DUTY OF THE SECRETARY OF**  
 6 **LABOR TO IMPLEMENT PROVISIONS OF CUR-**  
 7 **RENT LAW PROVIDING FOR EXEMPTIONS**  
 8 **AND SOLVENCY STANDARDS FOR MULTIPLE**  
 9 **EMPLOYER HEALTH PLANS.**

10 (a) RULES GOVERNING REGULATION OF MULTIPLE  
 11 EMPLOYER HEALTH PLANS.—Subtitle B of title I of the  
 12 Employee Retirement Income Security Act of 1974 (as  
 13 amended by the preceding provisions of this title) is  
 14 amended by inserting after part 6 the following new part:

15 **“PART 7—RULES GOVERNING REGULATION OF**  
 16 **MULTIPLE EMPLOYER HEALTH PLANS**

17 **“SEC. 701. DEFINITIONS.**

18 “For purposes of this part—

19 “(1) FULLY INSURED.—A particular benefit  
 20 under a group health plan or a multiple employer  
 21 welfare arrangement is ‘fully insured’ if such benefit  
 22 (irrespective of any recourse available against other  
 23 parties) is provided by an insurer or a health main-  
 24 tenance organization in a manner so that such bene-

1 fit constitutes insurance regulated by the law of a  
2 State (within the meaning of section 514(b)(2)(A)).

3 “(2) INSURER.—The term ‘insurer’ means an  
4 insurance company, insurance service, or insurance  
5 organization which is licensed to engage in the busi-  
6 ness of insurance in a State and which is subject to  
7 State law which regulates insurance (within the  
8 meaning of section 514(b)(2)(A)).

9 “(3) HEALTH MAINTENANCE ORGANIZATION.—  
10 The terms ‘health maintenance organization’  
11 means—

12 “(A) a Federally qualified health mainte-  
13 nance organization (as defined in section  
14 1301(a) of the Public Health Service Act (42  
15 U.S.C. 300e(a))),

16 “(B) an organization recognized under  
17 State law as a health maintenance organization,  
18 or

19 “(C) a similar organization regulated  
20 under State law for solvency in the same man-  
21 ner and to the same extent as such a health  
22 maintenance organization,

23 if it is subject to State law which regulates insur-  
24 ance (within the meaning of section 514(b)(2)(A)).

1           “(4) MULTIPLE EMPLOYER HEALTH PLAN.—

2           The term ‘multiple employer health plan’ means a  
3           multiple employer welfare arrangement which pro-  
4           vides medical care and which is or has been exempt  
5           under section 514(b)(6)(B).

6           “(5) PARTICIPATING EMPLOYER.—The term

7           ‘participating employer’ means, in connection with a  
8           multiple employer welfare arrangement, any em-  
9           ployer if any of its employees, or any of the individ-  
10          uals who are dependents (as defined under the terms  
11          of the arrangement) of its employees, are or were  
12          covered under such arrangement in connection with  
13          the employment of the employees.

14          “(6) SPONSOR.—The term ‘sponsor’ means, in

15          connection with a multiple employer welfare arrange-  
16          ment, the association or other entity which estab-  
17          lishes or maintains the arrangement.

18          “(7) STATE INSURANCE COMMISSIONER.—The

19          term ‘State insurance commissioner’ means the in-  
20          surance commissioner (or similar official) of a State.

1 **“SEC. 702. CLARIFICATION OF DUTY OF THE SECRETARY TO**  
2 **IMPLEMENT PROVISIONS OF CURRENT LAW**  
3 **PROVIDING FOR EXEMPTIONS AND SOL-**  
4 **VENCY STANDARDS FOR MULTIPLE EM-**  
5 **PLOYER HEALTH PLANS.**

6 “(a) TREATMENT AS EMPLOYEE WELFARE BENEFIT  
7 PLAN WHICH IS A GROUP HEALTH PLAN.—

8 “(1) IN GENERAL.—A multiple employer wel-  
9 fare arrangement—

10 “(A) under which the benefits consist sole-  
11 ly of medical care (disregarding such incidental  
12 benefits as the Secretary shall specify by regu-  
13 lation), and

14 “(B) under which some or all benefits are  
15 not fully insured,  
16 shall be treated for purposes of subtitle A and the  
17 other parts of this title as an employee welfare bene-  
18 fit plan which is a group health plan if the arrange-  
19 ment is exempt under section 514(b)(6)(B) in ac-  
20 cordance with this part.

21 “(2) EXCEPTION.—In the case of a multiple  
22 employer welfare arrangement which would be de-  
23 scribed in section 3(40)(A)(i) but solely for the fail-  
24 ure to meet the requirements of section 3(40)(C)(ii),  
25 paragraph (1) shall apply with respect to such ar-

1       rangement, but only with respect to benefits pro-  
2       vided thereunder which constitute medical care.

3       “(b) TREATMENT UNDER PREEMPTION RULES.—

4             “(1) IN GENERAL.—The Secretary shall pre-  
5       scribe regulations described in section  
6       514(b)(6)(B)(i), applicable to multiple employer wel-  
7       fare arrangements described in subparagraphs (A)  
8       and (B) of subsection (a)(1), providing a procedure  
9       for granting exemptions from section  
10      514(b)(6)(A)(ii) with respect to such arrangements.  
11      Under such regulations, any such arrangement  
12      treated under subsection (a) as an employee welfare  
13      benefit plan shall be deemed to be an arrangement  
14      described in section 514(b)(6)(B)(ii).

15            “(2) STANDARDS.—Under the procedure pre-  
16      scribed pursuant to paragraph (1), the Secretary  
17      shall grant an arrangement described in subsection  
18      (a) an exemption described in subsection (a) only if  
19      the Secretary finds that—

20               “(A) such exemption—

21                   “(i) is administratively feasible,

22                   “(ii) is not adverse to the interests of  
23                  the individuals covered under the arrange-  
24                  ment, and

1 “(iii) is protective of the rights and  
2 benefits of the individuals covered under  
3 the arrangement,

4 “(B) the application for the exemption  
5 meets the requirements of paragraph (3), and

6 “(C) the requirements of sections 703 and  
7 704 are met with respect to the arrangement.

8 “(3) INFORMATION TO BE INCLUDED IN APPLI-  
9 CATION FOR EXEMPTION.—An application for an ex-  
10 emption described in subsection (a) meets the re-  
11 quirements of this paragraph only if it includes, in  
12 a manner and form prescribed in regulations of the  
13 Secretary, at least the following information:

14 “(A) IDENTIFYING INFORMATION.—The  
15 names and addresses of—

16 “(i) the sponsor, and

17 “(ii) the members of the board of  
18 trustees of the arrangement.

19 “(B) STATES IN WHICH ARRANGEMENT IN-  
20 TENDS TO DO BUSINESS.—The States in which  
21 individuals covered under the arrangement are  
22 to be located and the number of such individ-  
23 uals expected to be located in each such State.

24 “(C) BONDING REQUIREMENTS.—Evidence  
25 provided by the board of trustees that the bond-

1 ing requirements of section 412 will be met as  
2 of the date of the application or (if later) com-  
3 mencement of operations.

4 “(D) PLAN DOCUMENTS.—A copy of the  
5 documents governing the arrangement (includ-  
6 ing any bylaws and trust agreements), the sum-  
7 mary plan description, and other material de-  
8 scribing the benefits and coverage that will be  
9 provided to individuals covered under the ar-  
10 rangement.

11 “(E) AGREEMENTS WITH SERVICE PROVID-  
12 ERS.—A copy of any agreements between the  
13 arrangement and contract administrators and  
14 other service providers.

15 “(F) FUNDING REPORT.—A report setting  
16 forth information determined as of a date with-  
17 in the 120-day period ending with the date of  
18 the application, including the following:

19 “(i) RESERVES.—A statement, cer-  
20 tified by the board of trustees of the ar-  
21 rangement, and a statement of actuarial  
22 opinion, signed by a qualified actuary, that  
23 all applicable requirements of section 705  
24 are or will be met in accordance with regu-  
25 lations which the Secretary shall prescribe.

1                   “(ii) ADEQUACY OF CONTRIBUTION  
2                   RATES.—A statement of actuarial opinion,  
3                   signed by a qualified actuary, which sets  
4                   forth a description of the extent to which  
5                   contribution rates are adequate to provide  
6                   for the payment of all obligations and the  
7                   maintenance of required reserves under the  
8                   arrangement for the 12-month period be-  
9                   ginning with such date within such 120-  
10                  day period, taking into account the ex-  
11                  pected coverage and experience of the ar-  
12                  rangement. If the contribution rates are  
13                  not fully adequate, the statement of actu-  
14                  arial opinion shall indicate the extent to  
15                  which the rates are inadequate and the  
16                  changes needed to ensure adequacy.

17                  “(iii) CURRENT AND PROJECTED  
18                  VALUE OF ASSETS AND LIABILITIES.—A  
19                  statement of actuarial opinion signed by a  
20                  qualified actuary, which sets forth the cur-  
21                  rent value of the assets and liabilities accu-  
22                  mulated under the arrangement and a pro-  
23                  jection of the assets, liabilities, income,  
24                  and expenses of the arrangement for the  
25                  12-month period referred to in clause (ii).



1           The income statement shall identify sepa-  
2           rately the arrangement's administrative ex-  
3           penses and claims.

4           “(iv) COSTS OF COVERAGE TO BE  
5           CHARGED AND OTHER EXPENSES.—A  
6           statement of the costs of coverage to be  
7           charged, including an itemization of  
8           amounts for administration, reserves, and  
9           other expenses associated with the oper-  
10          ation of the arrangement.

11          “(v) OTHER INFORMATION.—Any  
12          other information which may be prescribed  
13          in regulations of the Secretary as nec-  
14          essary to carry out the purposes of this  
15          part.

16          “(4) FILING FEE.—Under the procedure pre-  
17          scribed pursuant to paragraph (1), a multiple em-  
18          ployer welfare arrangement shall pay to the Sec-  
19          retary at the time of filing an application for an ex-  
20          emption referred to in subsection (a) a filing fee in  
21          the amount of \$5,000, which shall be available, to  
22          the extent provided in appropriation Acts, to the  
23          Secretary for the sole purpose of administering the  
24          exemption procedures applicable with respect to such  
25          arrangement.

1           “(5) CLASS EXEMPTION TREATMENT FOR EX-  
2        ISTING LARGE ARRANGEMENTS.—Under the proce-  
3        dure prescribed pursuant to paragraph (1), if—

4           “(A) at the time of application for an ex-  
5        emption under section 514(b)(6)(B) with re-  
6        spect to an arrangement which has been in ex-  
7        istence as of the date of the enactment of the  
8        Health Coverage Availability and Affordability  
9        Act of 1996 for at least 3 years, either (A) the  
10       arrangement covers at least 1,000 participants  
11       and beneficiaries, or (B) with respect to the ar-  
12       rangement there are at least 2,000 employees of  
13       eligible participating employers,

14          “(B) a complete application for the exemp-  
15       tion with respect to the arrangement has been  
16       filed and is pending, and

17          “(C) the application meets such require-  
18       ments (if any) as the Secretary may provide  
19       with respect to class exemptions under this sub-  
20       section,

21       the exemption shall be treated as having been grant-  
22       ed with respect to the arrangement unless and until  
23       the Secretary provides appropriate notice that the  
24       exemption has been denied.

1       “(c) FILING NOTICE OF EXEMPTION WITH  
2 STATES.—An exemption granted under section  
3 514(b)(6)(B) to a multiple employer welfare arrangement  
4 shall not be effective unless written notice of such exemp-  
5 tion is filed with the State insurance commissioner of each  
6 State in which at least 5 percent of the individuals covered  
7 under the arrangement are located. For purposes of this  
8 subsection, an individual shall be considered to be located  
9 in the State in which a known address of such individual  
10 is located or in which such individual is employed. The  
11 Secretary may by regulation provide in specified cases for  
12 the application of the preceding sentence with lesser per-  
13 centages in lieu of such 5 percent amount.

14       “(d) NOTICE OF MATERIAL CHANGES.—In the case  
15 of any multiple employer welfare arrangement exempt  
16 under section 514(b)(6)(B), descriptions of material  
17 changes in any information which was required to be sub-  
18 mitted with the application for the exemption under this  
19 part shall be filed in such form and manner as shall be  
20 prescribed in regulations of the Secretary. The Secretary  
21 may require by regulation prior notice of material changes  
22 with respect to specified matters which might serve as the  
23 basis for suspension or revocation of the exemption.

24       “(e) REPORTING REQUIREMENTS.—Under regula-  
25 tions of the Secretary, the requirements of sections 102,

1 103, and 104 shall apply with respect to any multiple em-  
2 ployer welfare arrangement which is or has been exempt  
3 under section 514(b)(6)(B) in the same manner and to  
4 the same extent as such requirements apply to employee  
5 welfare benefit plans, irrespective of whether such exemp-  
6 tion continues in effect. The annual report required under  
7 section 103 for any plan year in the case of any such mul-  
8 tiple employer welfare arrangement shall also include in-  
9 formation described in subsection (b)(3)(F) with respect  
10 to the plan year and, notwithstanding section  
11 104(a)(1)(A), shall be filed not later than 90 days after  
12 the close of the plan year.

13 “(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The  
14 board of trustees of each multiple employer welfare ar-  
15 rangement which is or has been exempt under section  
16 514(b)(6)(B) shall engage, on behalf of all covered individ-  
17 uals, a qualified actuary who shall be responsible for the  
18 preparation of the materials comprising information nec-  
19 essary to be submitted by a qualified actuary under this  
20 part. The qualified actuary shall utilize such assumptions  
21 and techniques as are necessary to enable such actuary  
22 to form an opinion as to whether the contents of the mat-  
23 ters reported under this part—

1           “(1) are in the aggregate reasonably related to  
2           the experience of the arrangement and to reasonable  
3           expectations, and

4           “(2) represent such actuary’s best estimate of  
5           anticipated experience under the arrangement.

6   The opinion by the qualified actuary shall be made with  
7   respect to, and shall be made a part of, the annual report.

8   **“SEC. 703. REQUIREMENTS RELATING TO SPONSORS,**  
9                   **BOARDS OF TRUSTEES, AND PLAN OPER-**  
10                  **ATIONS.**

11       “(a) IN GENERAL.—A complete application for an ex-  
12   emption under section 514(b)(6)(B) shall include informa-  
13   tion which the Secretary determines to be complete and  
14   accurate and sufficient to demonstrate that the following  
15   requirements are met with respect to the arrangement:

16           “(1) SPONSOR.—The sponsor is, and has been  
17           (together with its immediate predecessor, if any) for  
18           a continuous period of not less than 5 years before  
19           the date of the application, organized and main-  
20           tained in good faith, with a constitution and bylaws  
21           specifically stating its purpose and providing for  
22           periodic meetings on at least an annual basis, as a  
23           trade association, an industry association, a profes-  
24           sional association, or a chamber of commerce (or  
25           similar business group, including a corporation or

1 similar organization that operates on a cooperative  
2 basis (within the meaning of section 1381 of the In-  
3 ternal Revenue Code of 1986)), for substantial pur-  
4 poses other than that of obtaining or providing med-  
5 ical care (within the meaning of section 607(1)), and  
6 the applicant demonstrates to the satisfaction of the  
7 Secretary that the sponsor is established as a per-  
8 manent entity which receives the active support of  
9 its members and collects dues or contributions from  
10 its members on a periodic basis, without condi-  
11 tioning such dues or contributions on the basis of  
12 the health status of the employees of such members  
13 or the dependents of such employees or on the basis  
14 of participation in a group health plan. Any sponsor  
15 consisting of an association of entities meeting the  
16 preceding requirements of this paragraph shall be  
17 treated as meeting the requirements of this para-  
18 graph.

19 “(2) BOARD OF TRUSTEES.—The arrangement  
20 is operated, pursuant to a trust agreement, by a  
21 board of trustees which has complete fiscal control  
22 over the arrangement and which is responsible for  
23 all operations of the arrangement, and the board of  
24 trustees has in effect rules of operation and financial  
25 controls, based on a 3-year plan of operation, ade-

1       quate to carry out the terms of the arrangement and  
2       to meet all requirements of this title applicable to  
3       the arrangement. The members of the board of  
4       trustees are individuals selected from individuals  
5       who are the owners, officers, directors, or employees  
6       of the participating employers or who are partners  
7       in the participating employers and actively partici-  
8       pate in the business. No such member is an owner,  
9       officer, director, or employee of, or partner in, a con-  
10      tract administrator or other service provider to the  
11      arrangement, except that officers or employees of a  
12      sponsor which is a service provider (other than a  
13      contract administrator) to the arrangement may be  
14      members of the board if they constitute not more  
15      than 25 percent of the membership of the board and  
16      they do not provide services to the arrangement  
17      other than on behalf of the sponsor. The board has  
18      sole authority to approve applications for participa-  
19      tion in the arrangement and to contract with a serv-  
20      ice provider to administer the day-to-day affairs of  
21      the arrangement.

22           “(3) COVERED PERSONS.—The instruments  
23      governing the arrangement include a written instru-  
24      ment which provides that, effective upon becoming

1       an arrangement exempt under section  
2       514(b)(6)(B)—

3               “(A) all participating employers must be  
4       members or affiliated members of the sponsor,  
5       except that, in the case of a sponsor which is  
6       a professional association or other individual-  
7       based association, if at least one of the officers,  
8       directors, or employees of an employer, or at  
9       least one of the individuals who are partners in  
10      an employer and who actively participates in  
11      the business, is a member or affiliated member  
12      of the sponsor, participating employers may  
13      also include such employer,

14              “(B) all individuals thereafter commencing  
15      coverage under the arrangement must be—

16              “(i) active or retired owners (includ-  
17      ing self-employed individuals), officers, di-  
18      rectors, or employees of, or partners in,  
19      participating employers, or

20              “(ii) the beneficiaries of individuals  
21      described in clause (i), and

22              “(C) no participating employer may pro-  
23      vide health insurance coverage in the individual  
24      market for any employee not covered under the  
25      arrangement which is similar to the coverage



1 contemporaneously provided to employees of the  
2 employer under the arrangement, if such exclu-  
3 sion of the employee from coverage under the  
4 arrangement is based in whole or in part on the  
5 health status of the employee and such em-  
6 ployee would, but for such exclusion on such  
7 basis, be eligible for coverage under the ar-  
8 rangement.

9 “(4) INCLUSION OF ELIGIBLE EMPLOYERS AND  
10 EMPLOYEES.—No employer described in paragraph  
11 (3) is excluded as a participating employer (except  
12 to the extent that requirements of the type referred  
13 to in section 131(d)(2) of the Health Coverage  
14 Availability and Affordability Act of 1996 are not  
15 met) and the requirements of section 103 of such  
16 Act (as referred to in section 104(b)(1) of such Act)  
17 are met.

18 “(5) RESTRICTION ON VARIATIONS OF PREMIUM  
19 RATES.—Premium rates under the arrangement with  
20 respect to any particular employer do not vary on  
21 the basis of the claims experience of such employer  
22 alone.

23 “(b) TREATMENT OF FRANCHISE NETWORKS.—In  
24 the case of a multiple employer welfare arrangement which  
25 is established and maintained by a franchisor for a fran-

chise network consisting of its franchisees, the requirements of subsection (a)(1) shall not apply with respect to such network in any case in which such requirements would be met if the franchisor were deemed to be the sponsor referred to in subsection (a)(1), such network were deemed to be an association described in subsection (a)(1), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in subsection (a)(1).

“(c) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In the case of a multiple employer welfare arrangement in existence on March 6, 1996, which would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii) or (to the extent provided in regulations of the Secretary) solely for the failure to meet the requirements of subparagraph (D) or (F) of section 3(40)—

“(1) subsection (a)(1) shall not apply, and

“(2) the joint board of trustees shall be considered the board of trustees required under subsection (a)(2).

“(d) CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

“(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple

1 employer welfare arrangement are employees of a  
 2 single employer (within the meaning of clauses (i)  
 3 and (ii) of section 3(40)(B)), if all other employees  
 4 covered under the arrangement are employed by em-  
 5 ployers who are related to such single employer—

6 “(A) subsection (a)(1) shall not apply if  
 7 the sponsor of the arrangement is the person  
 8 who would be the plan sponsor if the related  
 9 employers were disregarded in determining  
 10 whether the requirements of section 3(40)(B)  
 11 are met, and

12 “(B) subsection (a)(2) shall be treated as  
 13 satisfied if the board of trustees is the named  
 14 fiduciary in connection with the arrangement.

15 “(2) RELATED EMPLOYERS.—For purposes of  
 16 paragraph (1), employers are ‘related’ if there is  
 17 among all such employers a common ownership in-  
 18 terest or a substantial commonality of business oper-  
 19 ations based on common suppliers or customers.

20 **“SEC. 704. OTHER REQUIREMENTS FOR EXEMPTION.**

21 “A multiple employer welfare arrangement exempt  
 22 under section 514(b)(6)(B) shall meet the following re-  
 23 quirements:

24 “(1) CONTENTS OF GOVERNING INSTRU-  
 25 MENTS.—The instruments governing the arrange-

1       ment include a written instrument, meeting the re-  
2       quirements of an instrument required under section  
3       402(a)(1), which—

4               “(A) provides that the board of trustees  
5       serves as the named fiduciary required for plans  
6       under section 402(a)(1) and serves in the ca-  
7       pacity of a plan administrator (referred to in  
8       section 3(16)(A)),

9               “(B) provides that the sponsor of the ar-  
10      rangement is to serve as plan sponsor (referred  
11      to in section 3(16)(B)), and

12              “(C) incorporates the requirements of sec-  
13      tion 705.

14              “(2) CONTRIBUTION RATES.—The contribution  
15      rates referred to in section 702(b)(3)(F)(ii) are ade-  
16      quate.

17              “(3) REGULATORY REQUIREMENTS.—Such  
18      other requirements as the Secretary may prescribe  
19      by regulation as necessary to carry out the purposes  
20      of this part.

21   **“SEC. 705. MAINTENANCE OF RESERVES.**

22              “(a) IN GENERAL.—Each multiple employer welfare  
23      arrangement which is or has been exempt under section  
24      514(b)(6)(B) and under which benefits are not fully in-

1   sured shall establish and maintain reserves, consisting  
2   of—

3           “(1) a reserve sufficient for unearned contribu-  
4   tions,

5           “(2) a reserve sufficient for benefit liabilities  
6   which have been incurred, which have not been satis-  
7   fied, and for which risk of loss has not yet been  
8   transferred, and for expected administrative costs  
9   with respect to such benefit liabilities, and

10          “(3) a reserve, in an amount recommended by  
11   the qualified actuary, for any other obligations of  
12   the arrangement.

13          “(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—  
14   The total of the reserves described in subsection (a)(2)  
15   shall not be less than an amount equal to the greater of—

16           “(1) 25 percent of expected incurred claims and  
17   expenses for the plan year, or

18           “(2) \$400,000.

19          “(c) REQUIRED MARGIN.—In determining the  
20   amounts of reserves required under this section in connec-  
21   tion with any multiple employer welfare arrangement, the  
22   qualified actuary shall include a margin for error and  
23   other fluctuations taking into account the specific cir-  
24   cumstances of such arrangement.

1       “(d) ADDITIONAL REQUIREMENTS.—The Secretary  
2 may provide such additional requirements relating to re-  
3 serves and excess/stop loss coverage as the Secretary con-  
4 sidered appropriate. Such requirements may be provided,  
5 by regulation or otherwise, with respect to any arrange-  
6 ment or any class of arrangements.

7       “(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COV-  
8 ERAGE.—The Secretary may provide for adjustments to  
9 the levels of reserves otherwise required under subsections  
10 (a) and (b) with respect to any arrangement or class of  
11 arrangements to take into account excess/stop loss cov-  
12 erage provided with respect to such arrangement or ar-  
13 rangements.

14       “(f) ALTERNATIVE MEANS OF COMPLIANCE.—The  
15 Secretary may permit an arrangement to substitute, for  
16 all or part of the requirements of this section, such secu-  
17 rity, guarantee, hold-harmless arrangement, or other fi-  
18 nancial arrangement as the Secretary determines to be  
19 adequate to enable the arrangement to fully meet all its  
20 financial obligations on a timely basis. The Secretary may  
21 take into account, for purposes of this subsection, evidence  
22 provided by the arrangement or sponsor which dem-  
23 onstrates an assumption of liability with respect to the ar-  
24 rangement. Such evidence may be in the form of a con-  
25 tract of indemnification, lien, bonding, insurance, letter of

1 credit, recourse under applicable terms of the arrangement  
2 in the form of assessments of participating employers, se-  
3 curity, or other financial arrangement.

4 **“SEC. 706. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
5 **MINATION.**

6 “Except as provided in section 707(b), a multiple em-  
7 ployer welfare arrangement which is or has been exempt  
8 under section 514(b)(6)(B) may terminate only if the  
9 board of trustees—

10 “(1) not less than 60 days before the proposed  
11 termination date, provides to the participants and  
12 beneficiaries a written notice of intent to terminate  
13 stating that such termination is intended and the  
14 proposed termination date,

15 “(2) develops a plan for winding up the affairs  
16 of the arrangement in connection with such termi-  
17 nation in a manner which will result in timely pay-  
18 ment of all benefits for which the arrangement is ob-  
19 ligated, and

20 “(3) submits such plan in writing to the Sec-  
21 retary.

22 Actions required under this paragraph shall be taken in  
23 such form and manner as may be prescribed in regulations  
24 of the Secretary.

1   **“SEC. 707. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
2                           **NATION.**

3           “(a) ACTIONS TO AVOID DEPLETION OF RE-  
4 SERVES.—A multiple employer welfare arrangement which  
5 is or has been exempt under section 514(b)(6)(B) shall  
6 continue to meet the requirements of section 705, irrespec-  
7 tive of whether such exemption continues in effect. The  
8 board of trustees of such arrangement shall determine  
9 quarterly whether the requirements of section 705 are  
10 met. In any case in which the committee determines that  
11 there is reason to believe that there is or will be a failure  
12 to meet such requirements, or the Secretary makes such  
13 a determination and so notifies the committee, the com-  
14 mittee shall immediately notify the qualified actuary en-  
15 gaged by the arrangement, and such actuary shall, not  
16 later than the end of the next following month, make such  
17 recommendations to the committee for corrective action as  
18 the actuary determines necessary to ensure compliance  
19 with section 705. Not later than 10 days after receiving  
20 from the actuary recommendations for corrective actions,  
21 the committee shall notify the Secretary (in such form and  
22 manner as the Secretary may prescribe by regulation) of  
23 such recommendations of the actuary for corrective action,  
24 together with a description of the actions (if any) that the  
25 committee has taken or plans to take in response to such  
26 recommendations. The committee shall thereafter report



1 to the Secretary, in such form and frequency as the Sec-  
2 retary may specify to the committee, regarding corrective  
3 action taken by the committee until the requirements of  
4 section 705 are met.

5 “(b) MANDATORY TERMINATION.—In any case in  
6 which—

7 “(1) the Secretary has been notified under sub-  
8 section (a) of a failure of a multiple employer wel-  
9 fare arrangement which is or has been exempt under  
10 section 514(b)(6)(B) to meet the requirements of  
11 section 705 and has not been notified by the board  
12 of trustees of the arrangement that corrective action  
13 has restored compliance with such requirements, and  
14 “(2) the Secretary determines that the continu-  
15 ing failure to meet the requirements of section 705  
16 can be reasonably expected to result in a continuing  
17 failure to pay benefits for which the arrangement is  
18 obligated,

19 the board of trustees of the arrangement shall, at the di-  
20 rection of the Secretary, terminate the arrangement and,  
21 in the course of the termination, take such actions as the  
22 Secretary may require, including recovering for the ar-  
23 rangement any liability under section 705(f), as necessary  
24 to ensure that the affairs of the arrangement will be, to  
25 the maximum extent possible, wound up in a manner

1 which will result in timely provision of all benefits for  
2 which the arrangement is obligated.

3 **“SEC. 708. ADDITIONAL RULES REGARDING STATE AU-**  
4 **THORITY.**

5 “(a) EXCLUSION OF ARRANGEMENTS FROM THE  
6 SMALL GROUP MARKET IN ANY STATE UPON STATE’S  
7 CERTIFICATION OF GUARANTEED ACCESS TO HEALTH  
8 INSURANCE COVERAGE IN SUCH STATE.—

9 “(1) IN GENERAL.—If a State certifies to the  
10 Secretary that such State provides to its residents  
11 guaranteed access to health insurance coverage, dur-  
12 ing the period for which such certification is in ef-  
13 fect, the law of such State may regulate any health  
14 care coverage provided in the small group market in  
15 such State (or prohibit the provision of such cov-  
16 erage) by a multiple employer welfare arrangement  
17 which is otherwise exempt under section  
18 514(b)(6)(B) and whose sponsor is described in sec-  
19 tion 703(a)(1), notwithstanding such exemption.  
20 Any such certification shall be in effect for such pe-  
21 riod, not greater than 3 years, as is designated in  
22 such certification. Such certification shall apply with  
23 respect to such arrangements as are identified, indi-  
24 vidually or by class, in the certification.

1           “(2) GUARANTEED ACCESS.—For purposes of  
 2           this subsection, the certification by a State that such  
 3           State provides ‘guaranteed access’ to health insur-  
 4           ance coverage to the residents of such State  
 5           means—

6                   “(A) certification that the number of resi-  
 7                   dents of such State who are covered by a group  
 8                   health plan or otherwise have health insurance  
 9                   coverage exceeds 90 percent of the total number  
 10                  of the residents of such State, or

11                  “(B) certification that—

12                           “(i) the small group market in such  
 13                           State provides guaranteed issue for em-  
 14                           ployees with respect to at least one option  
 15                           of health insurance coverage offered by in-  
 16                           surers and health maintenance organiza-  
 17                           tions in such market, and

18                           “(ii) the State has implemented rating  
 19                           reforms in the small group market in such  
 20                           State which are designed to make health  
 21                           insurance coverage more affordable.

22           “(b) EXCEPTIONS.—

23                   “(1) CERTAIN MULTISTATE ASSOCIATIONS.—  
 24                   Subsection (a) shall not apply in the case of a mul-  
 25                   tiple employer welfare arrangement operating in any

1 State which has made a certification under sub-  
2 section (a)(2)(B) if—

3 “(A) in the application for the exemption  
4 under section 514(b)(6)(B), the sponsor of such  
5 arrangement demonstrates to the Secretary (in  
6 such form and manner as shall be prescribed in  
7 regulations of the Secretary) that—

8 “(i) such sponsor operates in the ma-  
9 jority of the 50 States and in at least 2 of  
10 the regions of the United States, and

11 “(ii) the arrangement covers, or is to  
12 cover (in the case of a newly established  
13 arrangement), at least 7,500 participants  
14 and beneficiaries, and

15 “(B) at the time of such application, the  
16 arrangement does not have pending against it  
17 any enforcement action by the State.

18 “(2) EXISTING ARRANGEMENTS.—Subsection  
19 (a) shall not apply with respect to an arrangement  
20 operating in any State if—

21 “(A) such arrangement was operating in  
22 such State as of March 6, 1996, and

23 “(B) at the time of the application for the  
24 exemption under section 514(b)(6), the ar-

1           rangement does not have pending against it any  
2           enforcement action by the State.

3           “(3) LIMITATIONS.—Paragraphs (1) and (2)  
4           shall not apply in the case of any State which has  
5           made a certification under subsection (a) and which,  
6           as of January 1, 1996, had enacted a law that ei-  
7           ther—

8                   “(A) provided guaranteed issue of individ-  
9                   ual health insurance coverage offered by insur-  
10                  ers and health maintenance organizations in the  
11                  individual market using pure community rating  
12                  and did not provide for any transition period  
13                  (after the effective date of the guaranteed issue  
14                  requirement) in the implementation of pure  
15                  community rating; or

16                  “(B) required insurers offering health in-  
17                  surance coverage in connection with group  
18                  health plans to reimburse insurers offering indi-  
19                  vidual health insurance coverage for losses re-  
20                  sulting from those insurers offering individual  
21                  health insurance coverage on an open enroll-  
22                  ment basis.

23           Regulations under this part may provide for an ex-  
24           emption from the applicability of paragraph (1) in

1 the case of certain arrangements that are limited to  
2 a single industry.

3 “(c) ASSESSMENT AUTHORITY WITH RESPECT TO  
4 NEW ARRANGEMENTS.—

5 “(1) IN GENERAL.—Notwithstanding section  
6 514, a State may impose by law a premium tax on  
7 multiple employer welfare arrangements which are  
8 otherwise exempt under section 514(b)(6)(B) and  
9 the sponsor of which is described in section  
10 703(a)(1)—

11 “(A) in the case of an arrangement estab-  
12 lished after March 6, 1996, and

13 “(B) in the case of an arrangement in ex-  
14 istence as of March 6, 1996, if the arrangement  
15 commenced operations in such State after  
16 March 6, 1996.

17 “(2) PREMIUM TAX.—For purposes of this sub-  
18 section, the term ‘premium tax’ imposed by a State  
19 on a multiple employer welfare arrangement means  
20 any tax imposed by such State if—

21 “(A) such tax is computed by applying a  
22 rate to the amount of premiums or contribu-  
23 tions received by the arrangement from partici-  
24 pating employers located in such State with re-

1           spect to individuals covered under the arrange-  
2           ment who are residents of such State,

3           “(B) the rate of such tax does not exceed  
4           the rate of any tax imposed by such State on  
5           premiums or contributions received by insurers  
6           or health maintenance organizations for health  
7           insurance coverage offered in such State in con-  
8           nection with a group health plan,

9           “(C) such tax is otherwise nondiscrim-  
10          inatory, and

11          “(D) the amount of any such tax assessed  
12          on the arrangement is reduced by the amount  
13          of any tax or assessment imposed by the State  
14          on premiums or contributions received by insur-  
15          ers or health maintenance organizations for  
16          health insurance coverage (or other insurance  
17          related to the provision of medical care under  
18          the arrangement) provided by such insurers or  
19          health maintenance organizations in such State  
20          to such arrangement.

21          “(d) DEFINITIONS.—For purposes of this section—

22               “(1) SMALL GROUP MARKET.—The term ‘small  
23               group market’ means the health insurance coverage  
24               market under which individuals obtain health insur-  
25               ance coverage (directly or through any arrangement)

1 on behalf of themselves (and their dependents) on  
2 the basis of employment or other relationship with  
3 respect to a small employer.

4 “(2) SMALL EMPLOYER.—The term ‘small em-  
5 ployer’ means, in connection with a group health  
6 plan with respect to a calendar year, an employer  
7 who employs at least 2 but fewer than 51 employees  
8 on a typical business day in the year. For purposes  
9 of this paragraph, 2 or more trades or businesses,  
10 whether or not incorporated, shall be deemed a sin-  
11 gle employer if such trades or businesses are within  
12 the same control group (within the meaning of sec-  
13 tion 3(40)(B)(ii)).

14 “(3) REGION.—The term ‘region’ means any of  
15 the following regions:

16 “(A) The East Region, consisting of the  
17 States of Maine, New Hampshire, Vermont,  
18 New York, Massachusetts, Rhode Island, Con-  
19 necticut, New Jersey, Pennsylvania, Delaware,  
20 Maryland, West Virginia, and Ohio, and the  
21 District of Columbia.

22 “(B) The Southeast Region, consisting of  
23 the States of Texas, Arkansas, Louisiana, Mis-  
24 sissippi, Alabama, Georgia, Florida, South



1 Carolina, North Carolina, Virginia, and Ten-  
 2 nessee.

3 “(C) The Midwest Region, consisting of  
 4 the States of Montana, South Dakota, North  
 5 Dakota, Nebraska, Kansas, Oklahoma, Min-  
 6 nesota, Iowa, Missouri, Wisconsin, Michigan, Il-  
 7 linois, and Indiana.

8 “(D) The West Region, consisting of the  
 9 States of Oregon, Washington, Idaho, Nevada,  
 10 California, New Mexico, Arizona, Nebraska,  
 11 Wyoming, Hawaii, Alaska, Colorado, and  
 12 Utah.”.

13 (b) CONFORMING AMENDMENTS TO PREEMPTION  
 14 RULES.—

15 (1) Section 514(b)(6)(A)(i) of such Act (29  
 16 U.S.C. 1144(b)(6)(A)(i)) is amended by striking “is  
 17 fully insured” and inserting “under which all bene-  
 18 fits are fully insured”, and by inserting “and which  
 19 is not described in section 702(a)(1)” after “sub-  
 20 paragraph (B)”.

21 (2) Section 514(b)(6)(B) of such Act (29  
 22 U.S.C. 1144(b)(6)(B)) is amended—

23 (A) by inserting “(i)” after “(B)”;

1 (B) by striking “which are not fully in-  
2 sured” and inserting “under which any benefit  
3 is not fully insured”; and

4 (C) by striking “Any such exemption” and  
5 inserting:

6 “(ii) Subject to part 7, any exemption under clause  
7 (i)”.

8 (c) CONFORMING AMENDMENT TO DEFINITION OF  
9 PLAN SPONSOR.—Section 3(16)(B) of such Act (29  
10 U.S.C. 1002(16)(B)) is amended by adding at the end the  
11 following new sentence: “Such term also includes the spon-  
12 sor (as defined in section 701(6)) of a multiple employer  
13 welfare arrangement which is or has been a multiple em-  
14 ployer health plan (as defined in section 701(4)).”.

15 (d) DEFINITIONS.—

16 (1) GROUP HEALTH PLAN.—Section 3 of such  
17 Act (29 U.S.C. 1002) is amended by adding at the  
18 end the following new paragraph:

19 “(42) Except as otherwise provided in this title, the  
20 term ‘group health plan’ means an employee welfare bene-  
21 fit plan to the extent that the plan provides medical care  
22 (within the meaning of section 607(1)) to employees or  
23 their dependents (as defined under the terms of the plan)  
24 directly or through insurance, reimbursement, or other-  
25 wise.”.

1           (2) INCLUSION OF CERTAIN PARTNERS AND  
2           SELF-EMPLOYED SPONSORS IN DEFINITION OF PAR-  
3           TICIPANT.—Section 3(7) of such Act (29 U.S.C.  
4           1002(7)) is amended—

5                     (A) by inserting “(A)” after “(7)”; and

6                     (B) by adding at the end the following new  
7           paragraph:

8           “(B) In the case of a group health plan, such term  
9           includes—

10                    “(i) in connection with a group health plan  
11           maintained by a partnership, an individual who is a  
12           partner in relation to the partnership, or

13                    “(ii) in connection with a group health plan  
14           maintained by a self-employed individual (under  
15           which one or more employees are participants), the  
16           self-employed individual,

17           if such individual is or may become eligible to receive a  
18           benefit under the plan or such individual’s beneficiaries  
19           may be eligible to receive any such benefit.”.

20           (3) HEALTH INSURANCE COVERAGE.—Section 3  
21           of such Act (as amended by paragraph (1)) is  
22           amended further by adding at the end the following  
23           new paragraph:

24           “(43)(A) Except as provided in subparagraph (B),  
25           the term ‘health insurance coverage’ means benefits con-

1 sisting of medical care (provided directly, through insur-  
2 ance or reimbursement, or otherwise) under any hospital  
3 or medical service policy or certificate, hospital or medical  
4 service plan contract, or health maintenance organization  
5 group contract offered by an insurer or a health mainte-  
6 nance organization.

7 “(B) Such term does not include coverage under any  
8 separate policy, certificate, or contract only for one or  
9 more of any of the following:

10 “(i) Coverage for accident, credit-only, vision,  
11 disability income, long-term care, nursing home care,  
12 community-based care dental, on-site medical clinics,  
13 or employee assistance programs, or any combina-  
14 tion thereof.

15 “(ii) Medicare supplemental health insurance  
16 (within the meaning of section 1882(g)(1) of the So-  
17 cial Security Act (42 U.S.C. 1395ss(g)(1))) and  
18 similar supplemental coverage provided under a  
19 group health plan.

20 “(iii) Coverage issued as a supplement to liabil-  
21 ity insurance.

22 “(iv) Liability insurance, including general li-  
23 ability insurance and automobile liability insurance.

24 “(v) Workers’ compensation or similar insur-  
25 ance.

1 “(vi) Automobile medical-payment insurance.

2 “(vii) Coverage for a specified disease or illness.

3 “(viii) Hospital or fixed indemnity insurance.

4 “(ix) Short-term limited duration insurance.

5 “(x) Such other coverage, comparable to that  
6 described in previous clauses, as may be specified in  
7 regulations.”.

8 (4) MEDICAL CARE.—Section 607(1) of such  
9 Act (29 U.S.C. 1167(1)) is amended—

10 (A) by striking “The term” and inserting  
11 the following:

12 “(A) IN GENERAL.—The term”;

13 (B) by striking “(as defined” and all that  
14 follows through “1986”); and

15 (C) by adding at the end the following new  
16 subparagraph:

17 “(B) MEDICAL CARE.—For purposes of  
18 this paragraph, the term ‘medical care’  
19 means—

20 “(i) amounts paid for, or items or  
21 services in the form of, the diagnosis, cure,  
22 mitigation, treatment, or prevention of dis-  
23 ease, or amounts paid for, or items or serv-  
24 ices provided for, the purpose of affecting  
25 any structure or function of the body,

1 “(ii) amounts paid for, or services in  
 2 the form of, transportation primarily for  
 3 and essential to medical care referred to in  
 4 clause (i), and

5 “(iii) amounts paid for insurance cov-  
 6 ering medical care referred to in clauses (i)  
 7 and (ii).”.

8 (5) OTHER DEFINITIONS.—Section 514 of such  
 9 Act is further amended by adding at the end the fol-  
 10 lowing new subsection:

11 “(e) For purposes of this section, the terms ‘fully in-  
 12 sured’, ‘health maintenance organization’, and ‘insurer’  
 13 have the meanings given such terms in section 701.”.

14 (e) CLERICAL AMENDMENT.—The table of contents  
 15 in section 1 of the Employee Retirement Income Security  
 16 Act of 1974 (as amended by section 102(g)) is amended  
 17 by inserting after the item relating to section 609 the fol-  
 18 lowing new items:

“PART 7—RULES GOVERNING REGULATION OF MULTIPLE EMPLOYER  
 HEALTH PLANS

“Sec. 701. Definitions.

“Sec. 702. Clarification of duty of the Secretary to implement provisions of cur-  
 rent law providing for exemptions and solvency standards for  
 multiple employer health plans.

“Sec. 703. Requirements relating to sponsors, boards of trustees, and plan op-  
 erations.

“Sec. 704. Other requirements for exemption.

“Sec. 705. Maintenance of reserves.

“Sec. 706. Notice requirements for voluntary termination.

“Sec. 707. Corrective actions and mandatory termination.

“Sec. 708. Additional rules regarding State authority.”.

1 **SEC. 162. AFFORDABLE AND AVAILABLE FULLY INSURED**  
2 **HEALTH COVERAGE THROUGH VOLUNTARY**  
3 **HEALTH INSURANCE ASSOCIATIONS.**

4 Section 514 of the Employee Retirement Income Se-  
5 curity Act of 1974 is amended—

6 (1) by redesignating subsections (d) as sub-  
7 section (e); and

8 (2) by inserting after subsection (c) the follow-  
9 ing new subsection:

10 “(d)(1) The provisions of this title shall supercede  
11 any and all State laws which regulate insurance insofar  
12 as they may now or hereafter—

13 “(A) preclude an insurer or health maintenance  
14 organization from offering health insurance coverage  
15 under voluntary health insurance associations,

16 “(B) preclude an insurer or health maintenance  
17 organization from setting premium rates under a  
18 voluntary health insurance association based on the  
19 claims experience of the voluntary health insurance  
20 association (without varying the premium rates of  
21 any particular employer on the basis of the claims  
22 experience of such employer alone), or

23 “(C) require—

24 “(i) health insurance coverage in connec-  
25 tion with a voluntary health insurance associa-

1           tion to include specific items or services consist-  
2           ing of medical care, or

3           “(ii) an insurer or health maintenance or-  
4           ganization offering health insurance coverage in  
5           connection with a voluntary health insurance  
6           association to include in such health insurance  
7           coverage specific items or services consisting of  
8           medical care,

9           except to the extent that such State laws prohibit an  
10          exclusion for a specific disease in such health insur-  
11          ance coverage.

12       Subparagraph (C) shall apply only with respect to items  
13       and services which shall be specified in a list which shall  
14       be prescribed in regulations of the Secretary.

15       “(2)(A) If a State certifies to the Secretary that such  
16       State provides to its residents guaranteed access to health  
17       insurance coverage, during the period for which such cer-  
18       tification is in effect, the law of such State may regulate  
19       any health insurance coverage provided in the small group  
20       market in such State (or prohibit the provision of such  
21       coverage) by a voluntary health insurance association. Any  
22       such certification shall be in effect for such period, not  
23       greater than 3 years, as is designated in such certification.

24       “(B) For purposes of this paragraph, the certification  
25       by a State that such State provides ‘guaranteed access’



1 to health insurance coverage to the residents of such State  
2 means—

3 “(i) certification that the number of residents  
4 of such State who are covered by a group health  
5 plan or otherwise have health insurance coverage ex-  
6 ceeds 90 percent of the total number of the residents  
7 of such State, or

8 “(ii) certification that—

9 “(I) the small group market in such State  
10 provides guaranteed issue for employees with  
11 respect to at least one option of health insur-  
12 ance coverage offered by insurers and health  
13 maintenance organizations in such market, and

14 “(II) the State has implemented rating re-  
15 forms in the small group market in such State  
16 which are designed to make health insurance  
17 coverage more affordable.

18 “(3)(A) Paragraph (2) shall not apply in the case of  
19 any voluntary health insurance association with respect to  
20 any State if the qualified association demonstrates to the  
21 Secretary (in such form and manner as shall be prescribed  
22 in regulations of the Secretary) that—

23 “(i) such qualified association operates in the  
24 majority of the 50 States and in at least 2 of the  
25 regions of the United States,

1           “(ii) the arrangement covers, or is to cover (in  
2           the case of a newly established arrangement), at  
3           least 7,500 participants and beneficiaries, and

4           “(iii) under the terms of the arrangement, ei-  
5           ther—

6                   “(I) the qualified association does not ex-  
7                   clude from membership any small employer in  
8                   the State, or

9                   “(II) the arrangement accepts every small  
10                  employer in the State that applies for coverage.

11           “(B)(i) Subject to clause (ii), paragraph (2) shall not  
12           apply with respect to a voluntary health insurance associa-  
13           tion operating in any State if such association was operat-  
14           ing in such State as of March 6, 1996.

15           “(ii) Clause (i) shall apply in the case of an arrange-  
16           ment in connection with any State only if the qualified  
17           association demonstrates to the Secretary (in such form  
18           and manner as shall be prescribed in regulations of the  
19           Secretary) either—

20                   “(I) that the qualified association does not ex-  
21                   clude from membership any small employer in the  
22                   State, or

23                   “(II) that the arrangement accepts every small  
24                  employer in such State that applies for coverage.

1       “(C) Subparagraphs (A) and (B) shall not apply in  
2 the case of any State which has made a certification under  
3 paragraph (2) and which, as of January 1, 1996, had en-  
4 acted a law that either—

5           “(i) provided guaranteed issue of individual  
6 health insurance coverage offered by insurers and  
7 health maintenance organizations in the individual  
8 market using pure community rating and did not  
9 provide for any transition period (after the effective  
10 date of the guaranteed issue requirement) in the im-  
11 plementation of pure community rating; or

12           “(ii) required insurers offering health insurance  
13 coverage in connection with group health plans to re-  
14 imburse insurers offering individual health insurance  
15 coverage for losses resulting from those insurers of-  
16 fering individual health insurance coverage on an  
17 open enrollment basis.

18       “(5) For purposes of this subsection—

19           “(A) The term ‘voluntary health insurance as-  
20 sociation’ means a multiple employer welfare ar-  
21 rangement—

22           “(i) under which benefits include medical  
23 care (within the meaning of section 607(1)),

24           “(ii) under which all benefits consisting of  
25 such medical care are fully insured,

1           “(iii) which is maintained by a qualified  
2           association,

3           “(iv) under which no employer is excluded  
4           as a participating employer (except to the ex-  
5           tent that requirements of the type referred to in  
6           section 131(d)(2) of the Health Coverage Avail-  
7           ability and Affordability Act of 1996 are not  
8           met), the requirements of section 103 of such  
9           Act (as referred to in section 104(b)(1) of such  
10          Act) are met, and all health insurance coverage  
11          options are aggressively marketed to eligible  
12          employees and their dependents, and

13          “(v) under which, with respect to the oper-  
14          ations of the arrangement in any State, the  
15          health insurance coverage is provided by an in-  
16          surer or health maintenance organization to  
17          which the laws of such State applies.

18          “(B) The term ‘qualified association’ means an  
19          association with respect to which the following re-  
20          quirements are met:

21                 “(i) The sponsor of the association is, and  
22                 has been (together with its immediate prede-  
23                 cessor, if any) for a continuous period of not  
24                 less than 5 years, organized and maintained in  
25                 good faith, with a constitution and bylaws spe-

1 cifically stating its purpose, as a trade associa-  
2 tion, an industry association, a professional as-  
3 sociation, or a chamber of commerce (or similar  
4 business group), for substantial purposes other  
5 than that of obtaining or providing medical care  
6 (within the meaning of section 607(1)).

7 “(ii) The sponsor of the association is es-  
8 tablished as a permanent entity which receives  
9 the active support of its members.

10 “(iii) The constitution and bylaws of the  
11 association provide for periodic meetings on at  
12 least an annual basis.

13 “(iv) The association collects dues or con-  
14 tributions from its members on a periodic basis,  
15 without conditioning such dues or contributions  
16 on the basis of the health status of the employ-  
17 ees of such members or the dependents of such  
18 employees or on the basis of participation in a  
19 group health plan or voluntary health insurance  
20 association.

21 Such term includes a group of qualified associations,  
22 as defined in the preceding provisions of this clause.

23 “(C) The term ‘small group market’ means the  
24 health insurance coverage market under which indi-  
25 viduals obtain health insurance coverage (directly or

1 through any arrangement) on behalf of themselves  
2 (and their dependents) on the basis of employment  
3 or other relationship with respect to a small em-  
4 ployer.

5 “(D) The term ‘small employer’ means, in con-  
6 nection with a group health plan with respect to a  
7 calendar year, an employer who employs at least 2  
8 but fewer than 51 employees on a typical business  
9 day in the year. For purposes of this paragraph, 2  
10 or more trades or businesses, whether or not incor-  
11 porated, shall be deemed a single employer if such  
12 trades or businesses are within the same control  
13 group (within the meaning of section 3(40)(B)(ii)).

14 “(E) The term ‘region’ means any of the follow-  
15 ing regions:

16 “(i) The East Region, consisting of the  
17 States of Maine, New Hampshire, Vermont,  
18 New York, Massachusetts, Rhode Island, Con-  
19 necticut, New Jersey, Pennsylvania, Delaware,  
20 Maryland, West Virginia, and Ohio and the  
21 District of Columbia.

22 “(ii) The Southeast Region, consisting of  
23 the States of Texas, Arkansas, Louisiana, Mis-  
24 sissippi, Alabama, Georgia, Florida, South

1 Carolina, North Carolina, Virginia, and Ten-  
2 nessee.

3 “(iii) The Midwest Region, consisting of  
4 the States of Montana, South Dakota, North  
5 Dakota, Nebraska, Kansas, Oklahoma, Min-  
6 nesota, Iowa, Missouri, Wisconsin, Michigan, Il-  
7 linois, and Indiana.

8 “(iv) The West Region, consisting of the  
9 States of Oregon, Washington, Idaho, Nevada,  
10 California, New Mexico, Arizona, Nebraska,  
11 Wyoming, Hawaii, Alaska, Colorado, and  
12 Utah.”.

13 **SEC. 163. STATE AUTHORITY FULLY APPLICABLE TO SELF-**  
14 **INSURED MULTIPLE EMPLOYER WELFARE**  
15 **ARRANGEMENTS PROVIDING MEDICAL CARE**  
16 **WHICH ARE NOT EXEMPTED UNDER NEW**  
17 **PART 7.**

18 (a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the  
19 Employee Retirement Income Security Act of 1974 (29  
20 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting before  
21 the period the following: “, except that, in any such case,  
22 if the arrangement provides medical care (within the  
23 meaning of section 607(1)), such a law of any State may  
24 apply without limitation under this title”.

1 (b) CROSS-REFERENCE.—Section 514(b)(6) of such  
 2 Act (29 U.S.C. 1144(b)(6)) (as amended by section 301)  
 3 is amended by adding at the end the following new sub-  
 4 paragraph:

5 “(G) For additional rules relating to exemption from  
 6 subparagraph (A)(ii) of multiple employer health plans,  
 7 see part 7.”.

8 **SEC. 164. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
 9 **PLOYER ARRANGEMENTS.**

10 Section 3(40)(B) of the Employee Retirement Income  
 11 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-  
 12 ed—

13 (1) in clause (i), by inserting “for any plan year  
 14 of any such plan, or any fiscal year of any such  
 15 other arrangement,” after “single employer”, and by  
 16 inserting “during such year or at any time during  
 17 the preceding 1-year period” after “control group”;

18 (2) in clause (iii)—

19 (A) by striking “common control shall not  
 20 be based on an interest of less than 25 percent”  
 21 and inserting “an interest of greater than 25  
 22 percent may not be required as the minimum  
 23 interest necessary for common control”; and

24 (B) by striking “similar to” and inserting  
 25 “consistent and coextensive with”;



1           (3) by redesignating clauses (iv) and (v) as  
2           clauses (v) and (vi), respectively; and

3           (4) by inserting after clause (iii) the following  
4           new clause:

5           “(iv) in determining, after the application of  
6           clause (i), whether benefits are provided to employ-  
7           ees of two or more employers, the arrangement shall  
8           be treated as having only 1 participating employer  
9           if, after the application of clause (i), the number of  
10          individuals who are employees and former employees  
11          of any one participating employer and who are cov-  
12          ered under the arrangement is greater than 75 per-  
13          cent of the aggregate number of all individuals who  
14          are employees or former employees of participating  
15          employers and who are covered under the arrange-  
16          ment,”.

17 **SEC. 165. CLARIFICATION OF TREATMENT OF CERTAIN**  
18 **COLLECTIVELY BARGAINED ARRANGE-**  
19 **MENTS.**

20          (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-  
21 ployee Retirement Income Security Act of 1974 (29  
22 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

23           “(i)(I) under or pursuant to one or more collec-  
24          tive bargaining agreements which are reached pursu-  
25          ant to collective bargaining described in section 8(d)

1 of the National Labor Relations Act (29 U.S.C.  
2 158(d)) or paragraph Fourth of section 2 of the  
3 Railway Labor Act (45 U.S.C. 152, paragraph  
4 Fourth) or which are reached pursuant to labor-  
5 management negotiations under similar provisions of  
6 State public employee relations laws, and (II) in ac-  
7 cordance with subparagraphs (C), (D), and (E),”.

8 (b) LIMITATIONS.—Section 3(40) of such Act (29  
9 U.S.C. 1002(40)) is amended by adding at the end the  
10 following new subparagraphs:

11 “(C) A plan or other arrangement is established or  
12 maintained in accordance with this subparagraph only if  
13 the following requirements are met:

14 “(i) The plan or other arrangement, and the  
15 employee organization or any other entity sponsoring  
16 the plan or other arrangement, do not—

17 “(I) utilize the services of any licensed in-  
18 surance agent or broker for soliciting or enroll-  
19 ing employers or individuals as participating  
20 employers or covered individuals under the plan  
21 or other arrangement, or

22 “(II) pay a commission or any other type  
23 of compensation to a person, other than a full  
24 time employee of the employee organization (or  
25 a member of the organization to the extent pro-

1           vided in regulations of the Secretary), that is  
2           related either to the volume or number of em-  
3           ployers or individuals solicited or enrolled as  
4           participating employers or covered individuals  
5           under the plan or other arrangement, or to the  
6           dollar amount or size of the contributions made  
7           by participating employers or covered individ-  
8           uals to the plan or other arrangement,  
9           except to the extent that the services used by the  
10          plan, arrangement, organization, or other entity con-  
11          sist solely of preparation of documents necessary for  
12          compliance with the reporting and disclosure re-  
13          quirements of part 1 or administrative, investment,  
14          or consulting services unrelated to solicitation or en-  
15          rollment of covered individuals.

16               “(ii) As of the end of the preceding plan year,  
17          the number of covered individuals under the plan or  
18          other arrangement who are identified to the plan or  
19          arrangement and who are neither—

20                       “(I) employed within a bargaining unit  
21          covered by any of the collective bargaining  
22          agreements with a participating employer (nor  
23          covered on the basis of an individual’s employ-  
24          ment in such a bargaining unit), nor

1           “(II) present employees (or former employ-  
2           ees who were covered while employed) of the  
3           sponsoring employee organization, of an em-  
4           ployer who is or was a party to any of the col-  
5           lective bargaining agreements, or of the plan or  
6           other arrangement or a related plan or arrange-  
7           ment (nor covered on the basis of such present  
8           or former employment),  
9           does not exceed 15 percent of the total number of  
10          individuals who are covered under the plan or ar-  
11          rangement and who are present or former employees  
12          who are or were covered under the plan or arrange-  
13          ment pursuant to a collective bargaining agreement  
14          with a participating employer. The requirements of  
15          the preceding provisions of this clause shall be treat-  
16          ed as satisfied if, as of the end of the preceding plan  
17          year, such covered individuals are comprised solely  
18          of individuals who were covered individuals under  
19          the plan or other arrangement as of the date of the  
20          enactment of the Health Coverage Availability and  
21          Affordability Act 1996 and, as of the end of the pre-  
22          ceding plan year, the number of such covered indi-  
23          viduals does not exceed 25 percent of the total num-  
24          ber of present and former employees enrolled under  
25          the plan or other arrangement.

1           “(iii) The employee organization or other entity  
2           sponsoring the plan or other arrangement certifies  
3           to the Secretary each year, in a form and manner  
4           which shall be prescribed in regulations of the Sec-  
5           retary that the plan or other arrangement meets the  
6           requirements of clauses (i) and (ii).

7           “(D) A plan or arrangement is established or main-  
8           tained in accordance with this subparagraph only if—

9           “(i) all of the benefits provided under the plan  
10          or arrangement are fully insured (as defined in sec-  
11          tion 701(2)), or

12          “(ii)(I) the plan or arrangement is a multiem-  
13          ployer plan, and

14          “(II) the requirements of clause (B) of the pro-  
15          viso to clause (5) of section 302(c) of the Labor  
16          Management Relations Act, 1947 (29 U.S.C.  
17          186(c)) are met with respect to such plan or other  
18          arrangement.

19          “(E) A plan or arrangement is established or main-  
20          tained in accordance with this subparagraph only if—

21          “(i) the plan or arrangement is in effect as of  
22          the date of the enactment of the Health Coverage  
23          Availability and Affordability Act of 1996, or

24          “(ii) the employee organization or other entity  
25          sponsoring the plan or arrangement—

1           “(I) has been in existence for at least 3  
 2           years or is affiliated with another employee or-  
 3           ganization which has been in existence for at  
 4           least 3 years, or

5           “(II) demonstrates to the satisfaction of  
 6           the Secretary that the requirements of subpara-  
 7           graphs (C) and (D) are met with respect to the  
 8           plan or other arrangement.”.

9           (c) CONFORMING AMENDMENTS TO DEFINITIONS OF  
 10          PARTICIPANT AND BENEFICIARY.—Section 3(7) of such  
 11          Act (29 U.S.C. 1002(7)) is amended by adding at the end  
 12          the following new sentence: “Such term includes an indi-  
 13          vidual who is a covered individual described in paragraph  
 14          (40)(C)(ii).”.

15       **SEC. 166. TREATMENT OF CHURCH PLANS.**

16           (a) SPECIAL RULES FOR CHURCH PLANS.—

17           (1) IN GENERAL.—Part 7 of subtitle B of title  
 18          I of such Act (as added and amended by the preced-  
 19          ing provisions of this Act) is amended by adding at  
 20          the end the following new section:

21       **“SEC. 709. SPECIAL RULES FOR CHURCH PLANS.**

22           “(a) ELECTION FOR CHURCH PLANS.—

23           “(1) IN GENERAL.—Notwithstanding section  
 24          4(b)(2), if the church or convention or association of  
 25          churches which maintains a church plan covered

1       under this section makes an election with respect to  
2       such plan under this subsection (in such form and  
3       manner as the Secretary may by regulations pre-  
4       scribe), then, subject to this section, the provisions  
5       of this part (and other provisions of this title to the  
6       extent that they apply to group health plans which  
7       are multiple employer welfare arrangements) shall  
8       apply to such church plan, with respect to benefits  
9       provided under such plan consisting of medical care,  
10      as if—

11               “(A) section 4(b)(2) did not contain an ex-  
12               clusion for church plans, and

13               “(B) such plan were an arrangement eligi-  
14               ble to apply for an exemption under this part.

15               “(2) ELECTION IRREVOCABLE.—An election  
16       under this subsection with respect to any church  
17       plan shall be binding with respect to such plan, and,  
18       once made, shall be irrevocable.

19       “(b) COVERED CHURCH PLANS.—A church plan is  
20       covered under this section if such plan provides benefits  
21       which include medical care and some or all of such benefits  
22       are not fully insured.

23       “(c) SPONSOR AND BOARD OF TRUSTEES.—For pur-  
24       poses of this part, in the case of a church plan to which  
25       this part applies pursuant to an election under subsection

1 (a), in treating such plan as if it were a multiple employer  
2 welfare arrangement under this part—

3 “(1) the church, convention or association of  
4 churches, or other organization described in section  
5 3(33)(C)(i) which is the entity maintaining the plan  
6 shall be treated as the sponsor referred to in section  
7 703(a)(1), and the requirements of section 703(a)(1)  
8 shall not apply, and

9 “(2) the board of trustees, board of directors,  
10 or other similar governing body of such sponsor shall  
11 be treated as the board of trustees referred to in  
12 section 703(a)(2), and the requirements of section  
13 703(a)(2) shall be deemed satisfied with respect to  
14 the board of trustees.

15 “(d) DEEMED SATISFACTION OF TRUST REQUIRE-  
16 MENTS.—The requirements of section 403 shall not be  
17 treated as not satisfied with respect to a church plan to  
18 which this part applies pursuant to an election under sub-  
19 section (a) solely because assets of the plan are held by  
20 an organization described in section 3(33)(C)(i), if—

21 “(1) such organization is incorporated sepa-  
22 rately from the church or convention or association  
23 of churches involved, and

24 “(2) such assets with respect to medical care  
25 are separately accounted for.



1       “(e) DEEMED SATISFACTION OF EXCLUSIVE BENE-  
2 FIT REQUIREMENTS.—The requirements of section 404  
3 shall not be treated as not satisfied with respect to a  
4 church plan to which this part applies pursuant to an elec-  
5 tion under subsection (a) solely because assets of the plan  
6 which are in excess of reserves required for exemption  
7 under section 514(b)(6)(B) are held in a fund in which  
8 such assets are pooled with assets of other church plans,  
9 if the assets held by such fund may not, under the terms  
10 of the plan and the terms governing such fund, be used  
11 for, or diverted to, any purpose other than for the exclu-  
12 sive benefit of the participants and beneficiaries of the  
13 church plans whose assets are pooled in such fund.

14       “(f) INAPPLICABILITY OF CERTAIN PROVISIONS.—

15               “(1) PROHIBITED TRANSACTIONS.—Section 406  
16 shall not apply to a church plan by reason of an  
17 election under subsection (a).

18               “(2) CONTINUATION COVERAGE.—Section 601  
19 shall not apply to a church plan by reason of an  
20 election under subsection (a).”.

21       (b) CONFORMING AMENDMENTS.—

22               (1) Section 4(b)(2) of such Act (29 U.S.C.  
23 1003(b)(2)) is amended by inserting before the semi-  
24 colon the following: “, except with respect to provi-

1        sions made applicable under any election made  
2        under section 704(a) of this Act”.

3            (2) Section 514 of such Act (29 U.S.C. 1144)  
4        is amended—

5            (A) in subsection (a), by inserting “(in-  
6        cluding a church plan which is not exempt  
7        under section 4(b)(2) by reason of an election  
8        under section 704)” before the period in the  
9        first sentence; and

10          (B) in subsection (b)(2)(B), by inserting  
11        “and including a church plan which is not ex-  
12        empt under section 4(b)(2) by reason of an  
13        election under section 704” after “death bene-  
14        fits”.

15        (c) CLERICAL AMENDMENT.—The table of contents  
16        in section 1 of such Act (as amended by the preceding  
17        provisions of this title) is further amended by inserting  
18        after the item relating to section 703 the following new  
19        item:

      “Sec. 709. Special rules for church plans.”.

20        **SEC. 167. ENFORCEMENT PROVISIONS RELATING TO MUL-**  
21                                **TIPLE EMPLOYER WELFARE ARRANGE-**  
22                                **MENTS.**

23        (a) ENFORCEMENT OF FILING REQUIREMENTS.—  
24        Section 502 of the Employee Retirement Income Security

1 Act of 1974 (29 U.S.C. 1132) (as amended by sections  
2 102(c)) is further amended—

3 (1) in subsection (a)(6), by striking “paragraph  
4 (2) or (5)” and inserting “paragraph (2), (5), or  
5 (6)”; and

6 (2) by adding at the end of subsection (c) the  
7 following new paragraph:

8 “(6) The Secretary may assess a civil penalty against  
9 any person of up to \$1,000 a day from the date of such  
10 person’s failure or refusal to file the information required  
11 to be filed with the Secretary under section 101(g).”.

12 (b) ACTIONS BY STATES IN FEDERAL COURT.—Sec-  
13 tion 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

14 (1) in paragraph (8), by striking “or” at the  
15 end;

16 (2) in paragraph (9), by striking the period and  
17 inserting “, or”; and

18 (3) by adding at the end the following:

19 “(10) by a State official having authority under  
20 the law of such State to enforce the laws of such  
21 State regulating insurance, to enjoin any act or  
22 practice which violates any requirement under part  
23 7 for an exemption under section 514(b)(6)(B)  
24 which such State has the power to enforce pursuant  
25 to section 506(c)(1).”.

1       (c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
2 MISREPRESENTATIONS.—Section 501 of such Act (29  
3 U.S.C. 1131) is amended—

4           (1) by inserting “(a)” after “SEC. 501.”; and

5           (2) by adding at the end the following new sub-  
6 section:

7       “(b) Any person who, either willfully or with willful  
8 blindness, falsely represents, to any employee, any employ-  
9 ee’s beneficiary, any employer, the Secretary, or any State,  
10 an arrangement established or maintained for the purpose  
11 of offering or providing any benefit described in section  
12 3(1) to employees or their beneficiaries as—

13           “(1) being a multiple employer welfare arrange-  
14 ment to which an exemption has been granted under  
15 section 514(b)(6)(B),

16           “(2) having been established or maintained  
17 under or pursuant to one or more collective bargain-  
18 ing agreements which are reached pursuant to col-  
19 lective bargaining described in section 8(d) of the  
20 National Labor Relations Act (29 U.S.C. 158(d)) or  
21 paragraph Fourth of section 2 of the Railway Labor  
22 Act (45 U.S.C. 152, paragraph Fourth) or which are  
23 reached pursuant to labor-management negotiations  
24 under similar provisions of State public employee re-  
25 lations laws, or

1           “(3) being a plan or arrangement with respect  
2           to which the requirements of subparagraph (C), (D),  
3           or (E) of section 3(40) are met,  
4           shall, upon conviction, be imprisoned not more than five  
5           years, be fined under title 18, United States Code, or  
6           both.”.

7           (d) CESSATION OF ACTIVITIES IN ABSENCE OF EF-  
8           FECTIVE STATE REGULATION UNLESS STANDARDS  
9           UNDER ERISA EXEMPTION ARE MET.—Section 502 of  
10          such Act (29 U.S.C. 1132) is amended by adding at the  
11          end the following new subsection:

12          “(n)(1) Subject to paragraph (2), upon application  
13          by the Secretary showing the operation, promotion, or  
14          marketing of a multiple employer welfare arrangement  
15          providing benefits consisting of medical care (within the  
16          meaning of section 607(1)) that—

17                 “(A) is not licensed, registered, or otherwise ap-  
18                 proved under the insurance laws of the States in  
19                 which the arrangement offers or provides benefits,  
20                 and

21                 “(B) if there is in effect with respect to such  
22                 arrangement an exemption under section  
23                 514(b)(6)(B), is not operating in accordance with  
24                 the requirements under part 7 for such an exemp-  
25                 tion,

1 a district court of the United States shall enter an order  
2 requiring that the arrangement cease activities.

3 “(2) Paragraph (1) shall not apply in the case of a  
4 multiple employer welfare arrangement if the arrangement  
5 shows that—

6 “(A) all benefits under it referred to in para-  
7 graph (1) are fully insured, within the meaning of  
8 section 701(1), and

9 “(B) with respect to each State in which the ar-  
10 rangement offers or provides benefits, the arrange-  
11 ment is operating in accordance with applicable  
12 State insurance laws that are not superseded under  
13 section 514.

14 “(3) The court may grant such additional equitable  
15 relief, including any relief available under this title, as it  
16 deems necessary to protect the interests of the public and  
17 of persons having claims for benefits against the arrange-  
18 ment.”.

19 (e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—  
20 Section 503 of such Act (29 U.S.C. 1133) is amended by  
21 adding at the end (after and below paragraph (2)) the fol-  
22 lowing new sentence: “The terms of each multiple em-  
23 ployer health plan (within the meaning of section 701(4))  
24 shall require the board of trustees or the named fiduciary  
25 (as applicable) to ensure that the requirements of this sec-

tion are met in connection with claims filed under the plan.”.

**SEC. 168. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

“(c) STATE AUTHORITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

“(1) STATE ENFORCEMENT.—

“(A) AGREEMENTS WITH STATES.—A

State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary’s authority under sections 502 and 504 to enforce the requirements under section 514(d) or the requirements under part 7 for an exemption under section 514(b)(6)(B).

The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

“(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agree-

1           ment entered into under this paragraph may, if  
2           authorized under State law and to the extent  
3           consistent with such agreement, exercise the  
4           powers of the Secretary under this title which  
5           relate to such authority.

6           “(C) CONCURRENT AUTHORITY OF THE  
7           SECRETARY.—If the Secretary delegates author-  
8           ity to a State in an agreement entered into  
9           under subparagraph (A), the Secretary may  
10          continue to exercise such authority concurrently  
11          with the State.

12          “(D) RECOGNITION OF PRIMARY DOMICILE  
13          STATE.—In entering into any agreement with a  
14          State under subparagraph (A), the Secretary  
15          shall ensure that, as a result of such agreement  
16          and all other agreements entered into under  
17          subparagraph (A), only one State will be recog-  
18          nized, with respect to any particular multiple  
19          employer welfare arrangement, as the primary  
20          domicile State to which authority has been dele-  
21          gated pursuant to such agreements.

22          “(2) ASSISTANCE TO STATES.—The Secretary  
23          shall—

24                 “(A) provide enforcement assistance to the  
25                 States with respect to multiple employer welfare



1 arrangements, including, but not limited to, co-  
2 ordinating Federal and State efforts through  
3 the establishment of cooperative agreements  
4 with appropriate State agencies under which  
5 the Pension and Welfare Benefits Administra-  
6 tion keeps the States informed of the status of  
7 its cases and makes available to the States in-  
8 formation obtained by it,

9 “(B) provide continuing technical assist-  
10 ance to the States with respect to issues involv-  
11 ing multiple employer welfare arrangements  
12 and this Act,

13 “(C) make readily available to the States  
14 timely and complete responses to requests for  
15 advisory opinions on issues described in sub-  
16 paragraph (B), and

17 “(D) distribute copies of all advisory opin-  
18 ions described in subparagraph (C) to the State  
19 insurance commissioner of each State.”.

20 **SEC. 169. FILING AND DISCLOSURE REQUIREMENTS FOR**  
21 **MULTIPLE EMPLOYER WELFARE ARRANGE-**  
22 **MENTS OFFERING HEALTH BENEFITS.**

23 (a) IN GENERAL.—Section 101 of the Employee Re-  
24 tirement Income Security Act of 1974 (29 U.S.C. 1021)  
25 is amended—

1           (1) by redesignating subsection (g) as sub-  
2           section (i); and

3           (2) by inserting after subsection (f) the follow-  
4           ing new subsections:

5           “(g) REGISTRATION OF MULTIPLE EMPLOYER WEL-  
6           FARE ARRANGEMENTS.—(1) Each multiple employer wel-  
7           fare arrangement shall file with the Secretary a registra-  
8           tion statement described in paragraph (2) within 60 days  
9           before commencing operations (in the case of an arrange-  
10          ment commencing operations on or after January 1, 1997)  
11          and no later than February 15 of each year (in the case  
12          of an arrangement in operation since the beginning of  
13          such year), unless, as of the date by which such filing oth-  
14          erwise must be made, such arrangement provides no bene-  
15          fits consisting of medical care (within the meaning of sec-  
16          tion 607(1)).

17          “(2) Each registration statement—

18               “(A) shall be filed in such form, and contain  
19               such information concerning the multiple employer  
20               welfare arrangement and any persons involved in its  
21               operation (including whether coverage under the ar-  
22               rangement is fully insured), as shall be provided in  
23               regulations which shall be prescribed by the Sec-  
24               retary, and

1           “(B) if any benefits under the arrangement  
2           consisting of medical care (within the meaning of  
3           section 607(1)) are not fully insured, shall contain  
4           a certification that copies of such registration state-  
5           ment have been transmitted by certified mail to—

6                   “(i) in the case of an arrangement which  
7                   is a multiple employer health plan (as defined  
8                   in section 701(4)), the State insurance commis-  
9                   sioner of the domicile State of such arrange-  
10                  ment, or

11                  “(ii) in the case of an arrangement which  
12                  is not a multiple employer health plan, the  
13                  State insurance commissioner of each State in  
14                  which the arrangement is located.

15           “(3) The person or persons responsible for filing the  
16           annual registration statement are—

17                   “(A) the trustee or trustees so designated by  
18                   the terms of the instrument under which the mul-  
19                   tiple employer welfare arrangement is established or  
20                   maintained, or

21                   “(B) in the case of a multiple employer welfare  
22                   arrangement for which the trustee or trustees can-  
23                   not be identified, or upon the failure of the trustee  
24                   or trustees of an arrangement to file, the person or  
25                   persons actually responsible for the acquisition, dis-

1 position, control, or management of the cash or  
2 property of the arrangement, irrespective of whether  
3 such acquisition, disposition, control, or management  
4 is exercised directly by such person or persons or  
5 through an agent designated by such person or per-  
6 sons.

7 “(4) Any agreement entered into under section  
8 506(c) with a State as the primary domicile State with  
9 respect to any multiple employer welfare arrangement  
10 shall provide for simultaneous filings of reports required  
11 under this subsection with the Secretary and with the  
12 State insurance commissioner of such State.

13 “(5) For purposes of this subsection, the term ‘domi-  
14 cile State’ means, in connection with a multiple employer  
15 welfare arrangement, the State in which, according to the  
16 application for an exemption under this 514(b)(6)(B),  
17 most individuals to be covered under the arrangement are  
18 located, except that, in any case in which information con-  
19 tained in the latest annual report of the arrangement filed  
20 under this part indicates that most individuals covered  
21 under the arrangement are located in a different State,  
22 such term means such different State.

23 “(6) The Secretary may exempt from the require-  
24 ments of this subsection such class of multiple employer  
25 welfare arrangements as the Secretary deems appropriate.

1       “(h) FILING REQUIREMENTS FOR MULTIPLE EM-  
2   PLOYER WELFARE ARRANGEMENTS.—

3               “(1) IN GENERAL.—A multiple employer wel-  
4   fare arrangement which provides benefits consisting  
5   of medical care (within the meaning of section  
6   607(1)) shall issue to each participating employer—

7               “(A) a document equivalent to the sum-  
8   mary plan description required of plans under  
9   this part,

10              “(B) information describing the contribu-  
11   tion rates applicable to participating employers,  
12   and

13              “(C) a statement indicating—

14                   “(i) that the arrangement is not a li-  
15   censed insurer under the laws of any State,

16                   “(ii) the extent to which any benefits  
17   under the arrangement are fully insured,

18                   “(iii) if any benefits under the ar-  
19   rangement are not fully insured, whether  
20   the arrangement has been granted an ex-  
21   emption under section 514(b)(6)(B) (or  
22   whether such an exemption has ceased to  
23   be effective).

24              “(2) TIME FOR DISCLOSURE.—Such informa-  
25   tion shall be issued to employers within such reason-

1       able period of time before becoming participating  
2       employers as may be prescribed in regulations of the  
3       Secretary.”.

4       (b) EFFECTIVE DATES.—Section 101(g) of the Em-  
5       ployee Retirement Income Security Act of 1974 (added by  
6       subsection (a)) shall take effect on the date of the enact-  
7       ment of this Act. Section 101(h) of such Act (added by  
8       subsection (a)) shall take effect as provided in section 171.

9       **SEC. 170. SINGLE ANNUAL FILING FOR ALL PARTICIPATING**  
10       **EMPLOYERS.**

11       (a) IN GENERAL.—Section 110 of the Employee Re-  
12       tirement Income Security Act of 1974 (29 U.S.C. 1030)  
13       is amended by adding at the end the following new sub-  
14       section:

15       “(c) The Secretary shall prescribe by regulation or  
16       otherwise an alternative method providing for the filing  
17       of a single annual report (as referred to in section  
18       104(a)(1)(A)) with respect to all employers who are par-  
19       ticipating employers under a multiple employer welfare ar-  
20       rangement under which all coverage consists of medical  
21       care (within the meaning of section 607(1)) and is fully  
22       insured (as defined in section 701(1)).”.

23       (b) EFFECTIVE DATE.—The amendment made by  
24       subsection (a) shall take effect on the date of the enact-  
25       ment of this Act. The Secretary of Labor shall prescribe

1 the alternative method referred to in section 110(c) of the  
2 Employee Retirement Income Security Act of 1974, as  
3 added by such amendment, within 90 days after the date  
4 of the enactment of this Act.

5 **SEC. 171. EFFECTIVE DATE; TRANSITIONAL RULE.**

6 (a) EFFECTIVE DATE.—Except as otherwise provided  
7 in section 170(b), the amendments made by this subtitle  
8 shall take effect January 1, 1998. The Secretary shall  
9 issue all regulations necessary to carry out the amend-  
10 ments made by this subtitle before January 1, 1998.

11 (b) TRANSITIONAL RULE.—

12 (1) IN GENERAL.—If the sponsor of a multiple  
13 employer welfare arrangement which, as of the effec-  
14 tive date specified in subsection (a), provides bene-  
15 fits consisting of medical care (within the meaning  
16 of section 607(1) of the Employee Retirement In-  
17 come Security Act of 1974) files with the Secretary  
18 of Labor an application for an exemption under sec-  
19 tion 514(b)(6)(B) of such Act within 180 days after  
20 such date and the Secretary has not, as of 90 days  
21 after receipt of such application, found such applica-  
22 tion to be materially deficient, then section  
23 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A))  
24 shall not apply with respect to such arrangement

during the period following such date and ending on the earlier of—

(A) the date on which the Secretary denies the application under the amendments made by this title or determines, in the Secretary’s sole discretion, that such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such arrangement would be detrimental to the interests of individuals covered under such arrangement, or

(B) 18 months after such effective date.

(2) NO PENDING STATE ACTION.—Subparagraph (A) shall apply in the case of an arrangement only if, at the time of the application for the exemption under section 514(b)(6)(B), the arrangement does not have pending against it an enforcement action by a State.

## **Subtitle D—Definitions; General Provisions**

### **SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.**

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—Subject to the succeeding provisions of this subsection and subsection (d)(1), the term “group health plan” means an employee welfare benefit plan to the extent that the plan pro-



vides medical care (as defined in subsection (c)(9))  
to employees or their dependents (as defined under  
the terms of the plan) directly or through insurance,  
reimbursement, or otherwise, and includes a group  
health plan (within the meaning of section  
5000(b)(1) of the Internal Revenue Code of 1986).

(2) LIMITATION OF REQUIREMENTS TO PLANS  
WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The  
requirements of subtitle A and part 1 of subtitle B  
shall apply in the case of a group health plan for  
any plan year, or for health insurance coverage of-  
fered in connection with a group health plan for a  
year, only if the group health plan has two or more  
participants as current employees on the first day of  
the plan year.

(3) EXCLUSION OF PLANS WITH LIMITED COV-  
ERAGE.—An employee welfare benefit plan shall be  
treated as a group health plan under this title only  
with respect to medical care which is provided under  
the plan and which does not consist of coverage ex-  
cluded from the definition of health insurance cov-  
erage under subsection (c)(4)(B).

(4) TREATMENT OF CHURCH PLANS.—

1           (A) EXCLUSION.—The requirements of  
2           this title insofar as they apply to group health  
3           plans shall not apply to church plans.

4           (B) OPTIONAL DISREGARD IN DETERMIN-  
5           ING PERIOD OF COVERAGE.—For purposes of  
6           applying section 101(b)(3)(B)(i), a group health  
7           plan may elect to disregard periods of coverage  
8           of an individual under a church plan that, pur-  
9           suant to subparagraph (A), is not subject to the  
10          requirements of this title.

11         (5) TREATMENT OF GOVERNMENTAL PLANS.—

12           (A) ELECTION TO BE EXCLUDED.—If the  
13           plan sponsor of a governmental plan which is a  
14           group health plan to which the provisions of  
15           this subtitle otherwise apply makes an election  
16           under this paragraph for any specified period  
17           (in such form and manner as the Secretary of  
18           Health and Human Services may by regulations  
19           prescribe), then the requirements of this title  
20           insofar as they apply to group health plans  
21           shall not apply to such governmental plans for  
22           such period.

23           (B) OPTIONAL DISREGARD IN DETERMIN-  
24           ING PERIOD OF COVERAGE IF ELECTION  
25           MADE.—For purposes of applying section

1           101(b)(3)(B)(i), a group health plan may elect  
 2           to disregard periods of coverage of an individual  
 3           under a governmental plan that, under an elec-  
 4           tion under subparagraph (A), is not subject to  
 5           the requirements of this title.

6           (6) TREATMENT OF MEDICAID PLAN AS GROUP  
 7           HEALTH PLAN.—A State plan under title XIX of the  
 8           Social Security Act shall be treated as a group  
 9           health plan for purposes of applying section  
 10          101(c)(1), unless the State elects not to be so treat-  
 11          ed.

12          (7) TREATMENT OF MEDICARE AND INDIAN  
 13          HEALTH SERVICE PROGRAMS AS GROUP HEALTH  
 14          PLAN.—Title XVIII of the Social Security Act and  
 15          a program of the Indian Health Service shall be  
 16          treated as a group health plan for purposes of apply-  
 17          ing section 101(c)(1).

18          (b) INCORPORATION OF CERTAIN DEFINITIONS IN  
 19          EMPLOYEE RETIREMENT INCOME SECURITY ACT OF  
 20          1974.—Except as provided in this section, the terms “ben-  
 21          eficiary”, “church plan”, “employee”, “employee welfare  
 22          benefit plan”, “employer”, “governmental plan”, “multi-  
 23          employer plan”, “multiple employer welfare arrange-  
 24          ment”, “participant”, “plan sponsor”, and “State” have

1 the meanings given such terms in section 3 of the Em-  
2 ployee Retirement Income Security Act of 1974.

3 (c) OTHER DEFINITIONS.—For purposes of this title:

4 (1) APPLICABLE STATE AUTHORITY.—The term  
5 “applicable State authority” means, with respect to  
6 an insurer or health maintenance organization in a  
7 State, the State insurance commissioner or official  
8 or officials designated by the State to enforce the re-  
9 quirements of this title for the State involved with  
10 respect to such insurer or organization.

11 (2) BONA FIDE ASSOCIATION.—The term “bona  
12 fide association” means an association which—

13 (A) has been actively in existence for at  
14 least 5 years,

15 (B) has been formed and maintained in  
16 good faith for purposes other than obtaining in-  
17 surance,

18 (C) does not condition membership in the  
19 association on health status,

20 (D) makes health insurance coverage of-  
21 fered through the association available to all  
22 members regardless of health status,

23 (E) does not make health insurance cov-  
24 erage offered through the association available  
25 to any individual who is not a member (or de-

pendent of a member) of the association at the time the coverage is initially issued,

(F) does not impose preexisting condition exclusions except in a manner consistent with the requirements of sections 101 and 102 as they relate to group health plans, and

(G) provides for renewal and continuation of health insurance coverage in a manner consistent with the requirements of section 132 as they relate to the renewal and continuation in force of coverage in a group market.

(3) COBRA CONTINUATION PROVISION.—The term “COBRA continuation provision” means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609.

(C) Title XXII of the Public Health Service Act.

(4) HEALTH INSURANCE COVERAGE.—

1 (A) IN GENERAL.—Except as provided in  
2 subparagraph (B), the term “health insurance  
3 coverage” means benefits consisting of medical  
4 care (provided directly, through insurance or re-  
5 imbursement, or otherwise) under any hospital  
6 or medical service policy or certificate, hospital  
7 or medical service plan contract, or health  
8 maintenance organization group contract of-  
9 fered by an insurer or a health maintenance or-  
10 ganization.

11 (B) EXCEPTION.—Such term does not in-  
12 clude coverage under any separate policy, cer-  
13 tificate, or contract only for one or more of any  
14 of the following:

15 (i) Coverage for accident, credit-only,  
16 vision, disability income, long-term care,  
17 nursing home care, community-based care  
18 dental, on-site medical clinics, or employee  
19 assistance programs, or any combination  
20 thereof.

21 (ii) Medicare supplemental health in-  
22 surance (within the meaning of section  
23 1882(g)(1) of the Social Security Act (42  
24 U.S.C. 1395ss(g)(1))) and similar supple-

1           mental coverage provided under a group  
2           health plan.

3           (iii) Coverage issued as a supplement  
4           to liability insurance.

5           (iv) Liability insurance, including gen-  
6           eral liability insurance and automobile li-  
7           ability insurance.

8           (v) Workers' compensation or similar  
9           insurance.

10          (vi) Automobile medical-payment in-  
11          surance.

12          (vii) Coverage for a specified disease  
13          or illness.

14          (viii) Hospital or fixed indemnity in-  
15          surance.

16          (ix) Short-term limited duration in-  
17          surance.

18          (x) Such other coverage, comparable  
19          to that described in previous clauses, as  
20          may be specified in regulations prescribed  
21          under this title.

22          (5) HEALTH MAINTENANCE ORGANIZATION;  
23          HMO.—The terms “health maintenance organiza-  
24          tion” and “HMO” mean—

1 (A) a Federally qualified health mainte-  
2 nance organization (as defined in section  
3 1301(a) of the Public Health Service Act (42  
4 U.S.C. 300e(a))),

5 (B) an organization recognized under State  
6 law as a health maintenance organization, or

7 (C) a similar organization regulated under  
8 State law for solvency in the same manner and  
9 to the same extent as such a health mainte-  
10 nance organization,

11 if (other than for purposes of part 2 of subtitle B)  
12 it is subject to State law which regulates insurance  
13 (within the meaning of section 514(b)(2) of the Em-  
14 ployee Retirement Income Security Act of 1974).

15 (6) HEALTH STATUS.—The term “health sta-  
16 tus” includes, with respect to an individual, medical  
17 condition, claims experience, receipt of health care,  
18 medical history, genetic information, evidence of in-  
19 surability (including conditions arising out of acts of  
20 domestic violence), or disability.

21 (7) INDIVIDUAL HEALTH INSURANCE COV-  
22 ERAGE.—The term “individual health insurance cov-  
23 erage” means health insurance coverage offered to  
24 individuals if the coverage is not offered in connec-  
25 tion with a group health plan (other than such a



1 plan that has fewer than two participants as current  
2 employees on the first day of the plan year).

3 (8) INSURER.—The term “insurer” means an  
4 insurance company, insurance service, or insurance  
5 organization which is licensed to engage in the busi-  
6 ness of insurance in a State and which (except for  
7 purposes of part 2 of subtitle B) is subject to State  
8 law which regulates insurance (within the meaning  
9 of section 514(b)(2)(A) of the Employee Retirement  
10 Income Security Act of 1974).

11 (9) MEDICAL CARE.—The term “medical care”  
12 means—

13 (A) amounts paid for, or items or services  
14 in the form of, the diagnosis, cure, mitigation,  
15 treatment, or prevention of disease, or amounts  
16 paid for, or items or services provided for, the  
17 purpose of affecting any structure or function  
18 of the body,

19 (B) amounts paid for, or services in the  
20 form of, transportation primarily for and essen-  
21 tial to medical care referred to in subparagraph  
22 (A), and

23 (C) amounts paid for insurance covering  
24 medical care referred to in subparagraphs (A)  
25 and (B).

1           (10) NETWORK PLAN.—The term “network  
2       plan” means, with respect to health insurance cov-  
3       erage, an arrangement of an insurer or a health  
4       maintenance organization under which the financing  
5       and delivery of medical care are provided, in whole  
6       or in part, through a defined set of providers under  
7       contract with the insurer or health maintenance or-  
8       ganization.

9           (11) WAITING PERIOD.—The term “waiting pe-  
10      riod” means, with respect to a group health plan  
11      and an individual who is a potential participant or  
12      beneficiary in the plan, the minimum period that  
13      must pass with respect to the individual before the  
14      individual is eligible to be covered for benefits under  
15      the plan.

16      (d) TREATMENT OF PARTNERSHIPS.—

17           (1) TREATMENT AS A GROUP HEALTH PLAN.—  
18      Any plan, fund, or program which would not be (but  
19      for this paragraph) an employee welfare benefit plan  
20      and which is established or maintained by a partner-  
21      ship, to the extent that such plan, fund, or program  
22      provides medical care to present or former partners  
23      in the partnership or to their dependents (as defined  
24      under the terms of the plan, fund, or program), di-  
25      rectly or through insurance, reimbursement, or oth-

erwise, shall be treated (subject to paragraph (1)) as an employee welfare benefit plan which is a group health plan.

(2) TREATMENT OF PARTNERSHIP AND PARTNERS AND EMPLOYER AND PARTICIPANTS.—In the case of a group health plan—

(A) the term “employer” includes the partnership in relation to any partner; and

(B) the term “participant” includes—

(i) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(ii) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is or may become eligible to receive a benefit under the plan or such individual’s beneficiaries may be eligible to receive any such benefit.

(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—As used in this title:

1           (1) INDIVIDUAL MARKET.—The term “individ-  
2       ual market” means the market for health insurance  
3       coverage offered to individuals and not to employers  
4       or in connection with a group health plan and does  
5       not include the market for such coverage issued only  
6       by an insurer or HMO that makes such coverage  
7       available only on the basis of affiliation with a bona  
8       fide association (as defined in subsection (c)(2)).

9           (2) LARGE GROUP MARKET.—The term “large  
10      group market” means the market for health insur-  
11      ance coverage offered to employers (other than small  
12      employers) on behalf of their employees (and their  
13      dependents) and does not include health insurance  
14      coverage available solely in connection with a bona  
15      fide association (as defined in subsection (c)(2)).

16          (3) SMALL EMPLOYER.—The term “small em-  
17      ployer” means, in connection with a group health  
18      plan with respect to a calendar year, an employer  
19      who employs at least 2 but fewer than 51 employees  
20      on a typical business day in the year. All persons  
21      treated as a single employer under subsection (a) or  
22      (b) of section 52 of the Internal Revenue Code of  
23      1986 shall be treated as a single employer for pur-  
24      poses of this title.

1           (4) SMALL GROUP MARKET.—The term “small  
2       group market” means the health insurance market  
3       under which individuals obtain health insurance cov-  
4       erage (directly or through any arrangement) on be-  
5       half of themselves (and their dependents) on the  
6       basis of employment or other relationship with re-  
7       spect to a small employer and does not include  
8       health insurance coverage available solely in connec-  
9       tion with a bona fide association (as defined in sub-  
10      section (c)(2)).

11   **SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PRO-**  
12                           **TECTION.**

13       (a) STATE FLEXIBILITY TO PROVIDE GREATER PRO-  
14   TECTION.—Subject to subsection (b), nothing in this sub-  
15   title or subtitle A or B shall be construed to preempt State  
16   laws—

17           (1) that relate to matters not specifically ad-  
18       dressed in such subtitles; or

19           (2) that require insurers or HMOs—

20                   (A) to impose a limitation or exclusion of  
21       benefits relating to the treatment of a preexist-  
22       ing condition for a period that is shorter than  
23       the applicable period provided for under such  
24       subtitles;

1 (B) to allow individuals, participants, and  
2 beneficiaries to be considered to be in a period  
3 of previous qualifying coverage if such individ-  
4 ual, participant, or beneficiary experiences a  
5 lapse in coverage that is greater than the 60-  
6 day periods provided for under sections  
7 101(b)(3)(A), 101(b)(3)(B)(ii), and 102(b)(2);  
8 or

9 (C) in defining pre-existing condition, to  
10 have a look-back period that is shorter than the  
11 6-month period described in section  
12 101(b)(1)(A).

13 (b) NO OVERRIDE OF ERISA PREEMPTION.—Except  
14 as provided specifically in subtitle C, nothing in this Act  
15 shall be construed to affect or modify the provisions of  
16 section 514 of the Employee Retirement Income Security  
17 Act of 1974 (29 U.S.C. 1144).

18 **SEC. 193. EFFECTIVE DATE.**

19 (a) IN GENERAL.—Except as otherwise provided for  
20 in this title, the provisions of this title shall apply with  
21 respect to—

22 (1) group health plans, and health insurance  
23 coverage offered in connection with group health  
24 plans, for plan years beginning on or after January  
25 1, 1998, and

1 (2) individual health insurance coverage issued,  
2 renewed, in effect, or operated on or after July 1,  
3 1998.

4 (b) CONSIDERATION OF PREVIOUS COVERAGE.—The  
5 Secretaries of Health and Human Services, Treasury, and  
6 Labor shall jointly establish rules regarding the treatment  
7 (in determining qualified coverage periods under sections  
8 102(b) and 141(b)) of coverage before the applicable effective date specified in subsection (a).

10 (c) TIMELY ISSUANCE OF REGULATIONS.—The Secretaries of Health and Human Services, the Treasury, and  
11 Labor shall issue such regulations on a timely basis as  
12 may be required to carry out this title.

14 **SEC. 194. RULE OF CONSTRUCTION.**

15 Nothing in this title or any amendment made thereby  
16 may be construed to require (or to authorize any regulation that requires) the coverage of any specific procedure,  
17 treatment, or service under a group health plan or health  
18 insurance coverage.

20 **SEC. 195. FINDINGS RELATING TO EXERCISE OF COM-**  
21 **MERCE CLAUSE AUTHORITY.**

22 Congress finds the following in relation to the provisions of this title:

24 (1) Provisions in group health plans and health  
25 insurance coverage that impose certain pre-existing

1 conditions impact the ability of employees to seek  
2 employment in interstate commerce, thereby imped-  
3 ing such commerce.

4 (2) Health insurance coverage is commercial in  
5 nature and is in and affects interstate commerce.

6 (3) It is a necessary and proper exercise of  
7 Congressional authority to impose requirements  
8 under this title on group health plans and health in-  
9 surance coverage (including coverage offered to indi-  
10 viduals previously covered under group health plans)  
11 in order to promote commerce among the States.

12 (4) Congress, however, intends to defer to  
13 States, to the maximum extent practicable, in carry-  
14 ing out such requirements with respect to insurers  
15 and health maintenance organizations that are sub-  
16 ject to State regulation, consistent with the provi-  
17 sions of the Employee Retirement Income Security  
18 Act of 1974.



1 **TITLE II—PREVENTING HEALTH**  
 2 **CARE FRAUD AND ABUSE; AD-**  
 3 **MINISTRATIVE SIMPLIFICA-**  
 4 **TION; MEDICAL LIABILITY RE-**  
 5 **FORM**

6 **SEC. 200. REFERENCES IN TITLE.**

7 Except as otherwise specifically provided, whenever in  
 8 this title an amendment is expressed in terms of an  
 9 amendment to or repeal of a section or other provision,  
 10 the reference shall be considered to be made to that sec-  
 11 tion or other provision of the Social Security Act.

12 **Subtitle A—Fraud and Abuse**  
 13 **Control Program**

14 **SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.**

15 (a) ESTABLISHMENT OF PROGRAM.—Title XI (42  
 16 U.S.C. 1301 et seq.) is amended by inserting after section  
 17 1128B the following new section:

18 “FRAUD AND ABUSE CONTROL PROGRAM

19 “SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

20 “(1) IN GENERAL.—Not later than January 1,  
 21 1997, the Secretary, acting through the Office of the  
 22 Inspector General of the Department of Health and  
 23 Human Services, and the Attorney General shall es-  
 24 tablish a program—

1           “(A) to coordinate Federal, State, and  
2           local law enforcement programs to control fraud  
3           and abuse with respect to health plans,

4           “(B) to conduct investigations, audits,  
5           evaluations, and inspections relating to the de-  
6           livery of and payment for health care in the  
7           United States,

8           “(C) to facilitate the enforcement of the  
9           provisions of sections 1128, 1128A, and 1128B  
10          and other statutes applicable to health care  
11          fraud and abuse,

12          “(D) to provide for the modification and  
13          establishment of safe harbors and to issue advi-  
14          sory opinions and special fraud alerts pursuant  
15          to section 1128D, and

16          “(E) to provide for the reporting and dis-  
17          closure of certain final adverse actions against  
18          health care providers, suppliers, or practitioners  
19          pursuant to the data collection system estab-  
20          lished under section 1128E.

21          “(2) COORDINATION WITH HEALTH PLANS.—In  
22          carrying out the program established under para-  
23          graph (1), the Secretary and the Attorney General  
24          shall consult with, and arrange for the sharing of  
25          data with representatives of health plans.

1 “(3) GUIDELINES.—

2 “(A) IN GENERAL.—The Secretary and the  
3 Attorney General shall issue guidelines to carry  
4 out the program under paragraph (1). The pro-  
5 visions of sections 553, 556, and 557 of title 5,  
6 United States Code, shall not apply in the issu-  
7 ance of such guidelines.

8 “(B) INFORMATION GUIDELINES.—

9 “(i) IN GENERAL.—Such guidelines  
10 shall include guidelines relating to the fur-  
11 nishing of information by health plans,  
12 providers, and others to enable the Sec-  
13 retary and the Attorney General to carry  
14 out the program (including coordination  
15 with health plans under paragraph (2)).

16 “(ii) CONFIDENTIALITY.—Such guide-  
17 lines shall include procedures to assure  
18 that such information is provided and uti-  
19 lized in a manner that appropriately pro-  
20 tects the confidentiality of the information  
21 and the privacy of individuals receiving  
22 health care services and items.

23 “(iii) QUALIFIED IMMUNITY FOR PRO-  
24 VIDING INFORMATION.—The provisions of  
25 section 1157(a) (relating to limitation on

liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

“(4) ENSURING ACCESS TO DOCUMENTATION.—

The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

“(5) AUTHORITY OF INSPECTOR GENERAL.—

Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

“(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

“(1) REIMBURSEMENTS FOR INVESTIGA-

TIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are

1 ordered by a court, voluntarily agreed to by the  
2 payor, or otherwise.

3 “(2) CREDITING.—Funds received by the In-  
4 spector General under paragraph (1) as reimburse-  
5 ment for costs of conducting investigations shall be  
6 deposited to the credit of the appropriation from  
7 which initially paid, or to appropriations for similar  
8 purposes currently available at the time of deposit,  
9 and shall remain available for obligation for 1 year  
10 from the date of the deposit of such funds.

11 “(c) HEALTH PLAN DEFINED.—For purposes of this  
12 section, the term ‘health plan’ means a plan or program  
13 that provides health benefits, whether directly, through in-  
14 surance, or otherwise, and includes—

15 “(1) a policy of health insurance;

16 “(2) a contract of a service benefit organiza-  
17 tion; and

18 “(3) a membership agreement with a health  
19 maintenance organization or other prepaid health  
20 plan.”.

21 (b) ESTABLISHMENT OF HEALTH CARE FRAUD AND  
22 ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL IN-  
23 SURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i)  
24 is amended by adding at the end the following new sub-  
25 section:

1       “(k) HEALTH CARE FRAUD AND ABUSE CONTROL  
2 ACCOUNT.—

3               “(1) ESTABLISHMENT.—There is hereby estab-  
4 lished in the Trust Fund an expenditure account to  
5 be known as the ‘Health Care Fraud and Abuse  
6 Control Account’ (in this subsection referred to as  
7 the ‘Account’).

8               “(2) APPROPRIATED AMOUNTS TO TRUST  
9 FUND.—

10               “(A) IN GENERAL.—There are hereby ap-  
11 propriated to the Trust Fund—

12                       “(i) such gifts and bequests as may be  
13 made as provided in subparagraph (B);

14                       “(ii) such amounts as may be depos-  
15 ited in the Trust Fund as provided in sec-  
16 tions 242(b) and 249(c) of the Health Cov-  
17 erage Availability and Affordability Act of  
18 1996, and title XI; and

19                       “(iii) such amounts as are transferred  
20 to the Trust Fund under subparagraph  
21 (C).

22               “(B) AUTHORIZATION TO ACCEPT GIFTS.—  
23 The Trust Fund is authorized to accept on be-  
24 half of the United States money gifts and be-  
25 quests made unconditionally to the Trust Fund,

1 for the benefit of the Account or any activity fi-  
2 nanced through the Account.

3 “(C) TRANSFER OF AMOUNTS.—The Man-  
4 aging Trustee shall transfer to the Trust Fund,  
5 under rules similar to the rules in section 9601  
6 of the Internal Revenue Code of 1986, an  
7 amount equal to the sum of the following:

8 “(i) Criminal fines recovered in cases  
9 involving a Federal health care offense (as  
10 defined in section 982(a)(6)(B) of title 18,  
11 United States Code).

12 “(ii) Civil monetary penalties and as-  
13 sessments imposed in health care cases, in-  
14 cluding amounts recovered under titles XI,  
15 XVIII, and XIX, and chapter 38 of title  
16 31, United States Code (except as other-  
17 wise provided by law).

18 “(iii) Amounts resulting from the for-  
19 feiture of property by reason of a Federal  
20 health care offense.

21 “(iv) Penalties and damages obtained  
22 and otherwise creditable to miscellaneous  
23 receipts of the general fund of the Treas-  
24 ury obtained under sections 3729 through  
25 3733 of title 31, United States Code

1 (known as the False Claims Act), in cases  
2 involving claims related to the provision of  
3 health care items and services (other than  
4 funds awarded to a relator, for restitution  
5 or otherwise authorized by law).

6 “(3) APPROPRIATED AMOUNTS TO ACCOUNT  
7 FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

8 “(A) DEPARTMENTS OF HEALTH AND  
9 HUMAN SERVICES AND JUSTICE.—

10 “(i) IN GENERAL.—There are hereby  
11 appropriated to the Account from the  
12 Trust Fund such sums as the Secretary  
13 and the Attorney General certify are nec-  
14 essary to carry out the purposes described  
15 in subparagraph (C), to be available with-  
16 out further appropriation, in an amount  
17 not to exceed—

18 “(I) for fiscal year 1997,  
19 \$104,000,000,

20 “(II) for each of the fiscal years  
21 1998 through 2003, the limit for the  
22 preceding fiscal year, increased by 15  
23 percent; and



1 “(III) for each fiscal year after  
2 fiscal year 2003, the limit for fiscal  
3 year 2003.

4 “(ii) MEDICARE AND MEDICAID AC-  
5 TIVITIES.—For each fiscal year, of the  
6 amount appropriated in clause (i), the fol-  
7 lowing amounts shall be available only for  
8 the purposes of the activities of the Office  
9 of the Inspector General of the Depart-  
10 ment of Health and Human Services with  
11 respect to the medicare and medicaid pro-  
12 grams—

13 “(I) for fiscal year 1997, not less  
14 than \$60,000,000 and not more than  
15 \$70,000,000;

16 “(II) for fiscal year 1998, not  
17 less than \$80,000,000 and not more  
18 than \$90,000,000;

19 “(III) for fiscal year 1999, not  
20 less than \$90,000,000 and not more  
21 than \$100,000,000;

22 “(IV) for fiscal year 2000, not  
23 less than \$110,000,000 and not more  
24 than \$120,000,000;

1                   “(V) for fiscal year 2001, not  
2                   less than \$120,000,000 and not more  
3                   than \$130,000,000;

4                   “(VI) for fiscal year 2002, not  
5                   less than \$140,000,000 and not more  
6                   than \$150,000,000; and

7                   “(VII) for each fiscal year after  
8                   fiscal year 2002, not less than  
9                   \$150,000,000 and not more than  
10                  \$160,000,000.

11                  “(B) FEDERAL BUREAU OF INVESTIGA-  
12                  TION.—There are hereby appropriated from the  
13                  general fund of the United States Treasury and  
14                  hereby appropriated to the Account for transfer  
15                  to the Federal Bureau of Investigation to carry  
16                  out the purposes described in subparagraph  
17                  (C), to be available without further appropria-  
18                  tion—

19                         “(i) for fiscal year 1997, \$47,000,000;

20                         “(ii) for fiscal year 1998,  
21                         \$56,000,000;

22                         “(iii) for fiscal year 1999,  
23                         \$66,000,000;

24                         “(iv) for fiscal year 2000,  
25                         \$76,000,000;

1 “(v) for fiscal year 2001,  
2 \$88,000,000;

3 “(vi) for fiscal year 2002,  
4 \$101,000,000; and

5 “(vii) for each fiscal year after fiscal  
6 year 2002, \$114,000,000.

7 “(C) USE OF FUNDS.—The purposes de-  
8 scribed in this subparagraph are to cover the  
9 costs (including equipment, salaries and bene-  
10 fits, and travel and training) of the administra-  
11 tion and operation of the health care fraud and  
12 abuse control program established under section  
13 1128C(a), including the costs of—

14 “(i) prosecuting health care matters  
15 (through criminal, civil, and administrative  
16 proceedings);

17 “(ii) investigations;

18 “(iii) financial and performance audits  
19 of health care programs and operations;

20 “(iv) inspections and other evalua-  
21 tions; and

22 “(v) provider and consumer education  
23 regarding compliance with the provisions of  
24 title XI.

1           “(4) APPROPRIATED AMOUNTS TO ACCOUNT  
2           FOR MEDICARE INTEGRITY PROGRAM.—

3           “(A) IN GENERAL.—There are hereby ap-  
4           propriated to the Account from the Trust Fund  
5           for each fiscal year such amounts as are nec-  
6           essary to carry out the Medicare Integrity Pro-  
7           gram under section 1893, subject to subpara-  
8           graph (B) and to be available without further  
9           appropriation.

10           “(B) AMOUNTS SPECIFIED.—The amount  
11           appropriated under subparagraph (A) for a fis-  
12           cal year is as follows:

13           “(i) For fiscal year 1997, such  
14           amount shall be not less than  
15           \$430,000,000 and not more than  
16           \$440,000,000.

17           “(ii) For fiscal year 1998, such  
18           amount shall be not less than  
19           \$490,000,000 and not more than  
20           \$500,000,000.

21           “(iii) For fiscal year 1999, such  
22           amount shall be not less than  
23           \$550,000,000 and not more than  
24           \$560,000,000.

1                   “(iv) For fiscal year 2000, such  
2                   amount shall be not less than  
3                   \$620,000,000 and not more than  
4                   \$630,000,000.

5                   “(v) For fiscal year 2001, such  
6                   amount shall be not less than  
7                   \$670,000,000 and not more than  
8                   \$680,000,000.

9                   “(vi) For fiscal year 2002, such  
10                  amount shall be not less than  
11                  \$690,000,000 and not more than  
12                  \$700,000,000.

13                  “(vii) For each fiscal year after fiscal  
14                  year 2002, such amount shall be not less  
15                  than \$710,000,000 and not more than  
16                  \$720,000,000.

17                  “(5) ANNUAL REPORT.—The Secretary and the  
18                  Attorney General shall submit jointly an annual re-  
19                  port to Congress on the amount of revenue which is  
20                  generated and disbursed, and the justification for  
21                  such disbursements, by the Account in each fiscal  
22                  year.”.

1 **SEC. 202. MEDICARE INTEGRITY PROGRAM.**

2 (a) ESTABLISHMENT OF MEDICARE INTEGRITY PRO-  
3 GRAM.—Title XVIII is amended by adding at the end the  
4 following new section:

5 “MEDICARE INTEGRITY PROGRAM

6 “SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—  
7 There is hereby established the Medicare Integrity Pro-  
8 gram (in this section referred to as the ‘Program’) under  
9 which the Secretary shall promote the integrity of the  
10 medicare program by entering into contracts in accord-  
11 ance with this section with eligible private entities to carry  
12 out the activities described in subsection (b).

13 “(b) ACTIVITIES DESCRIBED.—The activities de-  
14 scribed in this subsection are as follows:

15 “(1) Review of activities of providers of services  
16 or other individuals and entities furnishing items  
17 and services for which payment may be made under  
18 this title (including skilled nursing facilities and  
19 home health agencies), including medical and utiliza-  
20 tion review and fraud review (employing similar  
21 standards, processes, and technologies used by pri-  
22 vate health plans, including equipment and software  
23 technologies which surpass the capability of the  
24 equipment and technologies used in the review of  
25 claims under this title as of the date of the enact-  
26 ment of this section).

1           “(2) Audit of cost reports.

2           “(3) Determinations as to whether payment  
3       should not be, or should not have been, made under  
4       this title by reason of section 1862(b), and recovery  
5       of payments that should not have been made.

6           “(4) Education of providers of services, bene-  
7       ficiaries, and other persons with respect to payment  
8       integrity and benefit quality assurance issues.

9           “(5) Developing (and periodically updating) a  
10      list of items of durable medical equipment in accord-  
11      ance with section 1834(a)(15) which are subject to  
12      prior authorization under such section.

13          “(c) ELIGIBILITY OF ENTITIES.—An entity is eligible  
14      to enter into a contract under the Program to carry out  
15      any of the activities described in subsection (b) if—

16           “(1) the entity has demonstrated capability to  
17      carry out such activities;

18           “(2) in carrying out such activities, the entity  
19      agrees to cooperate with the Inspector General of  
20      the Department of Health and Human Services, the  
21      Attorney General of the United States, and other  
22      law enforcement agencies, as appropriate, in the in-  
23      vestigation and deterrence of fraud and abuse in re-  
24      lation to this title and in other cases arising out of  
25      such activities;

1           “(3) the entity demonstrates to the Secretary  
2           that the entity’s financial holdings, interests, or rela-  
3           tionships will not interfere with its ability to perform  
4           the functions to be required by the contract in an ef-  
5           fective and impartial manner; and

6           “(4) the entity meets such other requirements  
7           as the Secretary may impose.

8   In the case of the activity described in subsection (b)(5),  
9   an entity shall be deemed to be eligible to enter into a  
10   contract under the Program to carry out the activity if  
11   the entity is a carrier with a contract in effect under sec-  
12   tion 1842.

13       “(d) PROCESS FOR ENTERING INTO CONTRACTS.—  
14   The Secretary shall enter into contracts under the Pro-  
15   gram in accordance with such procedures as the Secretary  
16   shall by regulation establish, except that such procedures  
17   shall include the following:

18           “(1) The Secretary shall determine the appro-  
19           priate number of separate contracts which are nec-  
20           essary to carry out the Program and the appropriate  
21           times at which the Secretary shall enter into such  
22           contracts.

23           “(2)(A) Except as provided in subparagraph  
24           (B), the provisions of section 1153(e)(1) shall apply



1 to contracts and contracting authority under this  
2 section.

3 “(B) Competitive procedures must be used  
4 when entering into new contracts under this section,  
5 or at any other time considered appropriate by the  
6 Secretary, except that the Secretary may contract  
7 with entities that are carrying out the activities de-  
8 scribed in this section pursuant to agreements under  
9 section 1816 or contracts under section 1842 in ef-  
10 fect on the date of the enactment of this section.

11 “(3) A contract under this section may be re-  
12 newed without regard to any provision of law requir-  
13 ing competition if the contractor has met or ex-  
14 ceeded the performance requirements established in  
15 the current contract.

16 “(e) LIMITATION ON CONTRACTOR LIABILITY.—The  
17 Secretary shall by regulation provide for the limitation of  
18 a contractor’s liability for actions taken to carry out a con-  
19 tract under the Program, and such regulation shall, to the  
20 extent the Secretary finds appropriate, employ the same  
21 or comparable standards and other substantive and proce-  
22 dural provisions as are contained in section 1157.”.

23 (b) ELIMINATION OF FI AND CARRIER RESPONSIBIL-  
24 ITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PRO-  
25 GRAM.—

1           (1)       RESPONSIBILITIES       OF       FISCAL  
2       INTERMEDIARIES UNDER PART A.—Section 1816  
3       (42 U.S.C. 1395h) is amended by adding at the end  
4       the following new subsection:

5       “(l) No agency or organization may carry out (or re-  
6       ceive payment for carrying out) any activity pursuant to  
7       an agreement under this section to the extent that the ac-  
8       tivity is carried out pursuant to a contract under the Med-  
9       icare Integrity Program under section 1893.”.

10           (2)       RESPONSIBILITIES OF CARRIERS UNDER  
11       PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is  
12       amended by adding at the end the following new  
13       paragraph:

14       “(6) No carrier may carry out (or receive payment  
15       for carrying out) any activity pursuant to a contract under  
16       this subsection to the extent that the activity is carried  
17       out pursuant to a contract under the Medicare Integrity  
18       Program under section 1893. The previous sentence shall  
19       not apply with respect to the activity described in section  
20       1893(b)(5) (relating to prior authorization of certain  
21       items of durable medical equipment under section  
22       1834(a)(15)).”.

23       **SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.**

24       (a) CLARIFICATION OF REQUIREMENT TO PROVIDE  
25       EXPLANATION OF MEDICARE BENEFITS.—The Secretary

1 of Health and Human Services (in this section referred  
2 to as the “Secretary”) shall provide an explanation of ben-  
3 efits under the medicare program under title XVIII of the  
4 Social Security Act with respect to each item or service  
5 for which payment may be made under the program which  
6 is furnished to an individual, without regard to whether  
7 or not a deductible or coinsurance may be imposed against  
8 the individual with respect to the item or service.

9 (b) PROGRAM TO COLLECT INFORMATION ON FRAUD  
10 AND ABUSE.—

11 (1) ESTABLISHMENT OF PROGRAM.—Not later  
12 than 3 months after the date of the enactment of  
13 this Act, the Secretary shall establish a program  
14 under which the Secretary shall encourage individ-  
15 uals to report to the Secretary information on indi-  
16 viduals and entities who are engaging or who have  
17 engaged in acts or omissions which constitute  
18 grounds for the imposition of a sanction under sec-  
19 tion 1128, section 1128A, or section 1128B of the  
20 Social Security Act, or who have otherwise engaged  
21 in fraud and abuse against the medicare program  
22 for which there is a sanction provided under law.  
23 The program shall discourage provision of, and not  
24 consider, information which is frivolous or otherwise

1 not relevant or material to the imposition of such a  
2 sanction.

3 (2) PAYMENT OF PORTION OF AMOUNTS COL-  
4 LECTED.—If an individual reports information to  
5 the Secretary under the program established under  
6 paragraph (1) which serves as the basis for the col-  
7 lection by the Secretary or the Attorney General of  
8 any amount of at least \$100 (other than any  
9 amount paid as a penalty under section 1128B of  
10 the Social Security Act), the Secretary may pay a  
11 portion of the amount collected to the individual  
12 (under procedures similar to those applicable under  
13 section 7623 of the Internal Revenue Code of 1986  
14 to payments to individuals providing information on  
15 violations of such Code).

16 (c) PROGRAM TO COLLECT INFORMATION ON PRO-  
17 GRAM EFFICIENCY.—

18 (1) ESTABLISHMENT OF PROGRAM.—Not later  
19 than 3 months after the date of the enactment of  
20 this Act, the Secretary shall establish a program  
21 under which the Secretary shall encourage individ-  
22 uals to submit to the Secretary suggestions on meth-  
23 ods to improve the efficiency of the medicare pro-  
24 gram.

1           (2) PAYMENT OF PORTION OF PROGRAM SAV-  
 2           INGS.—If an individual submits a suggestion to the  
 3           Secretary under the program established under  
 4           paragraph (1) which is adopted by the Secretary and  
 5           which results in savings to the program, the Sec-  
 6           retary may make a payment to the individual of  
 7           such amount as the Secretary considers appropriate.

8   **SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD**  
 9                           **AND ABUSE SANCTIONS TO FRAUD AND**  
 10                           **ABUSE AGAINST FEDERAL HEALTH CARE**  
 11                           **PROGRAMS.**

12       (a) IN GENERAL.—Section 1128B (42 U.S.C.  
 13 1320a–7b) is amended as follows:

14           (1) In the heading, by striking “MEDICARE OR  
 15       STATE HEALTH CARE PROGRAMS” and inserting  
 16       “FEDERAL HEALTH CARE PROGRAMS”.

17           (2) In subsection (a)(1), by striking “a program  
 18       under title XVIII or a State health care program (as  
 19       defined in section 1128(h))” and inserting “a Fed-  
 20       eral health care program”.

21           (3) In subsection (a)(5), by striking “a program  
 22       under title XVIII or a State health care program”  
 23       and inserting “a Federal health care program”.

24           (4) In the second sentence of subsection (a)—

1 (A) by striking “a State plan approved  
2 under title XIX” and inserting “a Federal  
3 health care program”, and

4 (B) by striking “the State may at its op-  
5 tion (notwithstanding any other provision of  
6 that title or of such plan)” and inserting “the  
7 administrator of such program may at its op-  
8 tion (notwithstanding any other provision of  
9 such program)”.

10 (5) In subsection (b), by striking “title XVIII  
11 or a State health care program” each place it ap-  
12 pears and inserting “a Federal health care pro-  
13 gram”.

14 (6) In subsection (c), by inserting “(as defined  
15 in section 1128(h))” after “a State health care pro-  
16 gram”.

17 (7) By adding at the end the following new sub-  
18 section:

19 “(f) For purposes of this section, the term ‘Federal  
20 health care program’ means—

21 “(1) any plan or program that provides health  
22 benefits, whether directly, through insurance, or oth-  
23 erwise, which is funded directly, in whole or in part,  
24 by the United States Government (other than the

1 health insurance program under chapter 89 of title  
2 5, United States Code); or

3 “(2) any State health care program, as defined  
4 in section 1128(h).”.

5 (b) EFFECTIVE DATE.—The amendments made by  
6 this section shall take effect on January 1, 1997.

7 **SEC. 205. GUIDANCE REGARDING APPLICATION OF HEALTH**  
8 **CARE FRAUD AND ABUSE SANCTIONS.**

9 Title XI (42 U.S.C. 1301 et seq.), as amended by  
10 section 201, is amended by inserting after section 1128C  
11 the following new section:

12 “GUIDANCE REGARDING APPLICATION OF HEALTH CARE  
13 FRAUD AND ABUSE SANCTIONS

14 “SEC. 1128D. (a) SOLICITATION AND PUBLICATION  
15 OF MODIFICATIONS TO EXISTING SAFE HARBORS AND  
16 NEW SAFE HARBORS.—

17 “(1) IN GENERAL.—

18 “(A) SOLICITATION OF PROPOSALS FOR  
19 SAFE HARBORS.—Not later than January 1,  
20 1997, and not less than annually thereafter, the  
21 Secretary shall publish a notice in the Federal  
22 Register soliciting proposals, which will be ac-  
23 cepted during a 60-day period, for—

24 “(i) modifications to existing safe har-  
25 bors issued pursuant to section 14(a) of  
26 the Medicare and Medicaid Patient and

1           Program Protection Act of 1987 (42  
2           U.S.C. 1320a–7b note);

3           “(ii) additional safe harbors specifying  
4           payment practices that shall not be treated  
5           as a criminal offense under section  
6           1128B(b) and shall not serve as the basis  
7           for an exclusion under section 1128(b)(7);

8           “(iii) advisory opinions to be issued  
9           pursuant to subsection (b); and

10          “(iv) special fraud alerts to be issued  
11          pursuant to subsection (c).

12          “(B) PUBLICATION OF PROPOSED MODI-  
13          FICATIONS AND PROPOSED ADDITIONAL SAFE  
14          HARBORS.—After considering the proposals de-  
15          scribed in clauses (i) and (ii) of subparagraph  
16          (A), the Secretary, in consultation with the At-  
17          torney General, shall publish in the Federal  
18          Register proposed modifications to existing safe  
19          harbors and proposed additional safe harbors, if  
20          appropriate, with a 60-day comment period.  
21          After considering any public comments received  
22          during this period, the Secretary shall issue  
23          final rules modifying the existing safe harbors  
24          and establishing new safe harbors, as appro-  
25          priate.



1           “(C) REPORT.—The Inspector General of  
2           the Department of Health and Human Services  
3           (in this section referred to as the ‘Inspector  
4           General’) shall, in an annual report to Congress  
5           or as part of the year-end semiannual report re-  
6           quired by section 5 of the Inspector General  
7           Act of 1978 (5 U.S.C. App.), describe the pro-  
8           posals received under clauses (i) and (ii) of sub-  
9           paragraph (A) and explain which proposals  
10          were included in the publication described in  
11          subparagraph (B), which proposals were not in-  
12          cluded in that publication, and the reasons for  
13          the rejection of the proposals that were not in-  
14          cluded.

15          “(2) CRITERIA FOR MODIFYING AND ESTAB-  
16          LISHING SAFE HARBORS.—In modifying and estab-  
17          lishing safe harbors under paragraph (1)(B), the  
18          Secretary may consider the extent to which provid-  
19          ing a safe harbor for the specified payment practice  
20          may result in any of the following:

21                 “(A) An increase or decrease in access to  
22                 health care services.

23                 “(B) An increase or decrease in the quality  
24                 of health care services.

1           “(C) An increase or decrease in patient  
2 freedom of choice among health care providers.

3           “(D) An increase or decrease in competi-  
4 tion among health care providers.

5           “(E) An increase or decrease in the ability  
6 of health care facilities to provide services in  
7 medically underserved areas or to medically un-  
8 derserved populations.

9           “(F) An increase or decrease in the cost to  
10 Federal health care programs (as defined in  
11 section 1128B(f)).

12           “(G) An increase or decrease in the poten-  
13 tial overutilization of health care services.

14           “(H) The existence or nonexistence of any  
15 potential financial benefit to a health care pro-  
16 fessional or provider which may vary based on  
17 their decisions of—

18                   “(i) whether to order a health care  
19 item or service; or

20                   “(ii) whether to arrange for a referral  
21 of health care items or services to a par-  
22 ticular practitioner or provider.

23           “(I) Any other factors the Secretary deems  
24 appropriate in the interest of preventing fraud

1           and abuse in Federal health care programs (as  
2           so defined).

3           “(b) ADVISORY OPINIONS.—

4           “(1) ISSUANCE OF ADVISORY OPINIONS.—The  
5           Secretary shall issue written advisory opinions as  
6           provided in this subsection.

7           “(2) MATTERS SUBJECT TO ADVISORY OPIN-  
8           IONS.—The Secretary shall issue advisory opinions  
9           as to the following matters:

10           “(A) What constitutes prohibited remun-  
11           eration within the meaning of section  
12           1128B(b).

13           “(B) Whether an arrangement or proposed  
14           arrangement satisfies the criteria set forth in  
15           section 1128B(b)(3) for activities which do not  
16           result in prohibited remuneration.

17           “(C) Whether an arrangement or proposed  
18           arrangement satisfies the criteria which the  
19           Secretary has established, or shall establish by  
20           regulation for activities which do not result in  
21           prohibited remuneration.

22           “(D) What constitutes an inducement to  
23           reduce or limit services to individuals entitled to  
24           benefits under title XVIII or title XIX or title  
25           XXI within the meaning of section 1128B(b).

1           “(E) Whether any activity or proposed ac-  
2           tivity constitutes grounds for the imposition of  
3           a sanction under section 1128, 1128A, or  
4           1128B.

5           “(3) MATTERS NOT SUBJECT TO ADVISORY  
6           OPINIONS.—Such advisory opinions shall not address  
7           the following matters:

8           “(A) Whether the fair market value shall  
9           be, or was paid or received for any goods, serv-  
10          ices or property.

11          “(B) Whether an individual is a bona fide  
12          employee within the requirements of section  
13          3121(d)(2) of the Internal Revenue Code of  
14          1986.

15          “(4) EFFECT OF ADVISORY OPINIONS.—

16          “(A) BINDING AS TO SECRETARY AND  
17          PARTIES INVOLVED.—Each advisory opinion is-  
18          sued by the Secretary shall be binding as to the  
19          Secretary and the party or parties requesting  
20          the opinion.

21          “(B) FAILURE TO SEEK OPINION.—The  
22          failure of a party to seek an advisory opinion  
23          may not be introduced into evidence to prove  
24          that the party intended to violate the provisions  
25          of sections 1128, 1128A, or 1128B.

1 “(5) REGULATIONS.—

2 “(A) IN GENERAL.—Not later than 180  
3 days after the date of the enactment of this sec-  
4 tion, the Secretary shall issue regulations to  
5 carry out this section. Such regulations shall  
6 provide for—

7 “(i) the procedure to be followed by a  
8 party applying for an advisory opinion;

9 “(ii) the procedure to be followed by  
10 the Secretary in responding to a request  
11 for an advisory opinion;

12 “(iii) the interval in which the Sec-  
13 retary shall respond;

14 “(iv) the reasonable fee to be charged  
15 to the party requesting an advisory opin-  
16 ion; and

17 “(v) the manner in which advisory  
18 opinions will be made available to the pub-  
19 lic.

20 “(B) SPECIFIC CONTENTS.—Under the  
21 regulations promulgated pursuant to subpara-  
22 graph (A)—

23 “(i) the Secretary shall be required to  
24 respond to a party requesting an advisory

1 opinion by not later than 30 days after the  
2 request is received; and

3 “(ii) the fee charged to the party re-  
4 questing an advisory opinion shall be equal  
5 to the costs incurred by the Secretary in  
6 responding to the request.

7 “(c) SPECIAL FRAUD ALERTS.—

8 “(1) IN GENERAL.—

9 “(A) REQUEST FOR SPECIAL FRAUD  
10 ALERTS.—Any person may present, at any  
11 time, a request to the Inspector General for a  
12 notice which informs the public of practices  
13 which the Inspector General considers to be  
14 suspect or of particular concern under the med-  
15 icare program or a State health care program,  
16 as defined in section 1128(h) (in this subsection  
17 referred to as a ‘special fraud alert’).

18 “(B) ISSUANCE AND PUBLICATION OF SPE-  
19 CIAL FRAUD ALERTS.—Upon receipt of a re-  
20 quest described in subparagraph (A), the In-  
21 spector General shall investigate the subject  
22 matter of the request to determine whether a  
23 special fraud alert should be issued. If appro-  
24 priate, the Inspector General shall issue a spe-  
25 cial fraud alert in response to the request. All

1 special fraud alerts issued pursuant to this sub-  
2 paragraph shall be published in the Federal  
3 Register.

4 “(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—  
5 In determining whether to issue a special fraud alert  
6 upon a request described in paragraph (1), the In-  
7 spector General may consider—

8 “(A) whether and to what extent the prac-  
9 tices that would be identified in the special  
10 fraud alert may result in any of the con-  
11 sequences described in subsection (a)(2); and

12 “(B) the volume and frequency of the con-  
13 duct that would be identified in the special  
14 fraud alert.”.

15 **Subtitle B—Revisions to Current**  
16 **Sanctions for Fraud and Abuse**

17 **SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION**  
18 **IN MEDICARE AND STATE HEALTH CARE PRO-**  
19 **GRAMS.**

20 (a) INDIVIDUAL CONVICTED OF FELONY RELATING  
21 TO HEALTH CARE FRAUD.—

22 (1) IN GENERAL.—Section 1128(a) (42 U.S.C.  
23 1320a–7(a)) is amended by adding at the end the  
24 following new paragraph:

1           “(3) FELONY CONVICTION RELATING TO  
2 HEALTH CARE FRAUD.—Any individual or entity  
3 that has been convicted after the date of the enact-  
4 ment of the Health Coverage Availability and Af-  
5 fordability Act of 1996, under Federal or State law,  
6 in connection with the delivery of a health care item  
7 or service or with respect to any act or omission in  
8 a health care program (other than those specifically  
9 described in paragraph (1)) operated by or financed  
10 in whole or in part by any Federal, State, or local  
11 government agency, of a criminal offense consisting  
12 of a felony relating to fraud, theft, embezzlement,  
13 breach of fiduciary responsibility, or other financial  
14 misconduct.”.

15           (2) CONFORMING AMENDMENT.—Paragraph (1)  
16 of section 1128(b) (42 U.S.C. 1320a–7(b)) is  
17 amended to read as follows:

18           “(1) CONVICTION RELATING TO FRAUD.—Any  
19 individual or entity that has been convicted after the  
20 date of the enactment of the Health Coverage Avail-  
21 ability and Affordability Act of 1996, under Federal  
22 or State law—

23                   “(A) of a criminal offense consisting of a  
24 misdemeanor relating to fraud, theft, embezzle-



1           ment, breach of fiduciary responsibility, or  
2           other financial misconduct—

3                   “(i) in connection with the delivery of  
4                   a health care item or service, or

5                   “(ii) with respect to any act or omis-  
6                   sion in a health care program (other than  
7                   those specifically described in subsection  
8                   (a)(1)) operated by or financed in whole or  
9                   in part by any Federal, State, or local gov-  
10                  ernment agency; or

11                  “(B) of a criminal offense relating to  
12                  fraud, theft, embezzlement, breach of fiduciary  
13                  responsibility, or other financial misconduct  
14                  with respect to any act or omission in a pro-  
15                  gram (other than a health care program) oper-  
16                  ated by or financed in whole or in part by any  
17                  Federal, State, or local government agency.”.

18           (b) INDIVIDUAL CONVICTED OF FELONY RELATING  
19 TO CONTROLLED SUBSTANCE.—

20                   (1) IN GENERAL.—Section 1128(a) (42 U.S.C.  
21           1320a–7(a)), as amended by subsection (a), is  
22           amended by adding at the end the following new  
23           paragraph:

24                   “(4) FELONY CONVICTION RELATING TO CON-  
25           TROLLED SUBSTANCE.—Any individual or entity

1 that has been convicted after the date of the enact-  
 2 ment of the Health Coverage Availability and Af-  
 3 fordability Act of 1996, under Federal or State law,  
 4 of a criminal offense consisting of a felony relating  
 5 to the unlawful manufacture, distribution, prescrip-  
 6 tion, or dispensing of a controlled substance.”.

7 (2) CONFORMING AMENDMENT.—Section  
 8 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

9 (A) in the heading, by striking “CONVIC-  
 10 TION” and inserting “MISDEMEANOR CONVIC-  
 11 TION”; and

12 (B) by striking “criminal offense” and in-  
 13 serting “criminal offense consisting of a mis-  
 14 demeanor”.

15 **SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**  
 16 **CLUSION FOR CERTAIN INDIVIDUALS AND**  
 17 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**  
 18 **SION FROM MEDICARE AND STATE HEALTH**  
 19 **CARE PROGRAMS.**

20 Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is  
 21 amended by adding at the end the following new subpara-  
 22 graphs:

23 “(D) In the case of an exclusion of an individual or  
 24 entity under paragraph (1), (2), or (3) of subsection (b),  
 25 the period of the exclusion shall be 3 years, unless the

1 Secretary determines in accordance with published regula-  
 2 tions that a shorter period is appropriate because of miti-  
 3 gating circumstances or that a longer period is appro-  
 4 priate because of aggravating circumstances.

5 “(E) In the case of an exclusion of an individual or  
 6 entity under subsection (b)(4) or (b)(5), the period of the  
 7 exclusion shall not be less than the period during which  
 8 the individual’s or entity’s license to provide health care  
 9 is revoked, suspended, or surrendered, or the individual  
 10 or the entity is excluded or suspended from a Federal or  
 11 State health care program.

12 “(F) In the case of an exclusion of an individual or  
 13 entity under subsection (b)(6)(B), the period of the exclu-  
 14 sion shall be not less than 1 year.”.

15 **SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**  
 16 **OWNERSHIP OR CONTROL INTEREST IN**  
 17 **SANCTIONED ENTITIES.**

18 Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended  
 19 by adding at the end the following new paragraph:

20 “(15) INDIVIDUALS CONTROLLING A SANC-  
 21 TIONED ENTITY.—(A) Any individual—

22 “(i) who has a direct or indirect ownership  
 23 or control interest in a sanctioned entity and  
 24 who knows or should know (as defined in sec-  
 25 tion 1128A(i)(6)) of the action constituting the

1 basis for the conviction or exclusion described  
 2 in subparagraph (B); or

3 “(ii) who is an officer or managing em-  
 4 ployee (as defined in section 1126(b)) of such  
 5 an entity.

6 “(B) For purposes of subparagraph (A), the  
 7 term ‘sanctioned entity’ means an entity—

8 “(i) that has been convicted of any offense  
 9 described in subsection (a) or in paragraph (1),  
 10 (2), or (3) of this subsection; or

11 “(ii) that has been excluded from partici-  
 12 pation under a program under title XVIII or  
 13 under a State health care program.”.

14 **SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PER-**  
 15 **SONS FOR FAILURE TO COMPLY WITH STATU-**  
 16 **TORY OBLIGATIONS.**

17 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-  
 18 TIONERS AND PERSONS FAILING TO MEET STATUTORY  
 19 OBLIGATIONS.—

20 (1) IN GENERAL.—The second sentence of sec-  
 21 tion 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is  
 22 amended by striking “may prescribe)” and inserting  
 23 “may prescribe, except that such period may not be  
 24 less than 1 year)”.

1           (2) CONFORMING AMENDMENT.—Section  
 2       1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended  
 3       by striking “shall remain” and inserting “shall (sub-  
 4       ject to the minimum period specified in the second  
 5       sentence of paragraph (1)) remain”.

6       (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-  
 7       TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)  
 8       (42 U.S.C. 1320c–5(b)(1)) is amended—

9           (1) in the second sentence, by striking “and de-  
 10       termines” and all that follows through “such obliga-  
 11       tions,”; and

12          (2) by striking the third sentence.

13 **SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE**  
 14 **HEALTH MAINTENANCE ORGANIZATIONS.**

15       (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR  
 16       ANY PROGRAM VIOLATIONS.—

17          (1) IN GENERAL.—Section 1876(i)(1) (42  
 18       U.S.C. 1395mm(i)(1)) is amended by striking “the  
 19       Secretary may terminate” and all that follows and  
 20       inserting “in accordance with procedures established  
 21       under paragraph (9), the Secretary may at any time  
 22       terminate any such contract or may impose the in-  
 23       termediate sanctions described in paragraph (6)(B)  
 24       or (6)(C) (whichever is applicable) on the eligible or-

1        organization if the Secretary determines that the orga-  
2        nization—

3            “(A) has failed substantially to carry out the  
4        contract;

5            “(B) is carrying out the contract in a manner  
6        substantially inconsistent with the efficient and ef-  
7        fective administration of this section; or

8            “(C) no longer substantially meets the applica-  
9        ble conditions of subsections (b), (c), (e), and (f).”.

10           (2) OTHER INTERMEDIATE SANCTIONS FOR  
11        MISCELLANEOUS PROGRAM VIOLATIONS.—Section  
12        1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by  
13        adding at the end the following new subparagraph:

14           “(C) In the case of an eligible organization for which  
15        the Secretary makes a determination under paragraph (1)  
16        the basis of which is not described in subparagraph (A),  
17        the Secretary may apply the following intermediate sanc-  
18        tions:

19            “(i) Civil money penalties of not more than  
20        \$25,000 for each determination under paragraph (1)  
21        if the deficiency that is the basis of the determina-  
22        tion has directly adversely affected (or has the sub-  
23        stantial likelihood of adversely affecting) an individ-  
24        ual covered under the organization’s contract.

1           “(ii) Civil money penalties of not more than  
2           \$10,000 for each week beginning after the initiation  
3           of procedures by the Secretary under paragraph (9)  
4           during which the deficiency that is the basis of a de-  
5           termination under paragraph (1) exists.

6           “(iii) Suspension of enrollment of individuals  
7           under this section after the date the Secretary noti-  
8           fies the organization of a determination under para-  
9           graph (1) and until the Secretary is satisfied that  
10          the deficiency that is the basis for the determination  
11          has been corrected and is not likely to recur.”.

12           (3) PROCEDURES FOR IMPOSING SANCTIONS.—

13          Section 1876(i) (42 U.S.C. 1395mm(i)) is amended  
14          by adding at the end the following new paragraph:

15          “(9) The Secretary may terminate a contract with an  
16          eligible organization under this section or may impose the  
17          intermediate sanctions described in paragraph (6) on the  
18          organization in accordance with formal investigation and  
19          compliance procedures established by the Secretary under  
20          which—

21                 “(A) the Secretary first provides the organiza-  
22                 tion with the reasonable opportunity to develop and  
23                 implement a corrective action plan to correct the de-  
24                 ficiencies that were the basis of the Secretary’s de-

1 termination under paragraph (1) and the organiza-  
 2 tion fails to develop or implement such a plan;

3 “(B) in deciding whether to impose sanctions,  
 4 the Secretary considers aggravating factors such as  
 5 whether an organization has a history of deficiencies  
 6 or has not taken action to correct deficiencies the  
 7 Secretary has brought to the organization’s atten-  
 8 tion;

9 “(C) there are no unreasonable or unnecessary  
 10 delays between the finding of a deficiency and the  
 11 imposition of sanctions; and

12 “(D) the Secretary provides the organization  
 13 with reasonable notice and opportunity for hearing  
 14 (including the right to appeal an initial decision) be-  
 15 fore imposing any sanction or terminating the con-  
 16 tract.”.

17 (4) CONFORMING AMENDMENTS.—Section  
 18 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is  
 19 amended by striking the second sentence.

20 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-  
 21 TIONS.—Section 1876(i)(7)(A) (42 U.S.C.  
 22 1395mm(i)(7)(A)) is amended by striking “an agreement”  
 23 and inserting “a written agreement”.



1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply with respect to contract years be-  
3 ginning on or after January 1, 1996.

4 **SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PEN-**  
5 **ALTIES FOR DISCOUNTING AND MANAGED**  
6 **CARE ARRANGEMENTS.**

7 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.  
8 1320a–7b(b)(3)) is amended—

9 (1) by striking “and” at the end of subpara-  
10 graph (D);

11 (2) by striking the period at the end of sub-  
12 paragraph (E) and inserting “; and”; and

13 (3) by adding at the end the following new sub-  
14 paragraph:

15 “(F) any remuneration between an organization  
16 and an individual or entity providing items or serv-  
17 ices, or a combination thereof, pursuant to a written  
18 agreement between the organization and the individ-  
19 ual or entity if the organization is an eligible organi-  
20 zation under section 1876 or if the written agree-  
21 ment places the individual or entity at substantial fi-  
22 nancial risk for the cost or utilization of the items  
23 or services, or a combination thereof, which the indi-  
24 vidual or entity is obligated to provide, whether  
25 through a withhold, capitation, incentive pool, per

1 diem payment, or any other similar risk arrange-  
2 ment which places the individual or entity at sub-  
3 stantial financial risk.”.

4 (b) EFFECTIVE DATE.—The amendments made by  
5 this section shall apply to written agreements entered into  
6 on or after January 1, 1997.

7 **SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSI-**  
8 **TION OF ASSETS IN ORDER TO OBTAIN MED-**  
9 **ICAID BENEFITS.**

10 Section 1128B(a) (42 U.S.C. 1320a–7b(a)) is  
11 amended—

12 (1) by striking “or” at the end of paragraph  
13 (4);

14 (2) by adding “or” at the end of paragraph (5);  
15 and

16 (3) by inserting after paragraph (5) the follow-  
17 ing new paragraph:

18 “(6) knowingly and willfully disposes of assets  
19 (including by any transfer in trust) in order for an  
20 individual to become eligible for medical assistance  
21 under a State plan under title XIX, if disposing of  
22 the assets results in the imposition of a period of in-  
23 eligibility for such assistance under section  
24 1917(c),”.

1 **SEC. 218. EFFECTIVE DATE.**

2 Except as otherwise provided, the amendments made  
3 by this subtitle shall take effect January 1, 1997.

4 **Subtitle C—Data Collection**

5 **SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD**  
6 **AND ABUSE DATA COLLECTION PROGRAM.**

7 (a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.),  
8 as amended by sections 201 and 205, is amended by in-  
9 serting after section 1128D the following new section:

10 “HEALTH CARE FRAUD AND ABUSE DATA COLLECTION  
11 PROGRAM

12 “SEC. 1128E. (a) GENERAL PURPOSE.—Not later  
13 than January 1, 1997, the Secretary shall establish a na-  
14 tional health care fraud and abuse data collection program  
15 for the reporting of final adverse actions (not including  
16 settlements in which no findings of liability have been  
17 made) against health care providers, suppliers, or practi-  
18 tioners as required by subsection (b), with access as set  
19 forth in subsection (c).

20 “(b) REPORTING OF INFORMATION.—

21 “(1) IN GENERAL.—Each Government agency  
22 and health plan shall report any final adverse action  
23 (not including settlements in which no findings of li-  
24 ability have been made) taken against a health care  
25 provider, supplier, or practitioner.

1           “(2) INFORMATION TO BE REPORTED.—The in-  
2           formation to be reported under paragraph (1) in-  
3           cludes:

4                   “(A) The name and TIN (as defined in  
5                   section 7701(a)(41) of the Internal Revenue  
6                   Code of 1986) of any health care provider, sup-  
7                   plier, or practitioner who is the subject of a  
8                   final adverse action.

9                   “(B) The name (if known) of any health  
10                  care entity with which a health care provider,  
11                  supplier, or practitioner is affiliated or associ-  
12                  ated.

13                  “(C) The nature of the final adverse action  
14                  and whether such action is on appeal.

15                  “(D) A description of the acts or omissions  
16                  and injuries upon which the final adverse action  
17                  was based, and such other information as the  
18                  Secretary determines by regulation is required  
19                  for appropriate interpretation of information re-  
20                  ported under this section.

21           “(3) CONFIDENTIALITY.—In determining what  
22           information is required, the Secretary shall include  
23           procedures to assure that the privacy of individuals  
24           receiving health care services is appropriately pro-  
25           tected.

1           “(4) TIMING AND FORM OF REPORTING.—The  
2           information required to be reported under this sub-  
3           section shall be reported regularly (but not less often  
4           than monthly) and in such form and manner as the  
5           Secretary prescribes. Such information shall first be  
6           required to be reported on a date specified by the  
7           Secretary.

8           “(5) TO WHOM REPORTED.—The information  
9           required to be reported under this subsection shall  
10          be reported to the Secretary.

11          “(c) DISCLOSURE AND CORRECTION OF INFORMA-  
12          TION.—

13               “(1) DISCLOSURE.—With respect to the infor-  
14          mation about final adverse actions (not including  
15          settlements in which no findings of liability have  
16          been made) reported to the Secretary under this sec-  
17          tion respecting a health care provider, supplier, or  
18          practitioner, the Secretary shall, by regulation, pro-  
19          vide for—

20                       “(A) disclosure of the information, upon  
21                       request, to the health care provider, supplier, or  
22                       licensed practitioner, and

23                       “(B) procedures in the case of disputed ac-  
24                       curacy of the information.

1           “(2) CORRECTIONS.—Each Government agency  
2           and health plan shall report corrections of informa-  
3           tion already reported about any final adverse action  
4           taken against a health care provider, supplier, or  
5           practitioner, in such form and manner that the Sec-  
6           retary prescribes by regulation.

7           “(d) ACCESS TO REPORTED INFORMATION.—

8           “(1) AVAILABILITY.—The information in this  
9           database shall be available to Federal and State gov-  
10          ernment agencies and health plans pursuant to pro-  
11          cedures that the Secretary shall provide by regula-  
12          tion.

13          “(2) FEES FOR DISCLOSURE.—The Secretary  
14          may establish or approve reasonable fees for the dis-  
15          closure of information in this database (other than  
16          with respect to requests by Federal agencies). The  
17          amount of such a fee shall be sufficient to recover  
18          the full costs of operating the database. Such fees  
19          shall be available to the Secretary or, in the Sec-  
20          retary’s discretion to the agency designated under  
21          this section to cover such costs.

22          “(e) PROTECTION FROM LIABILITY FOR REPORT-  
23          ING.—No person or entity, including the agency des-  
24          ignated by the Secretary in subsection (b)(5) shall be held  
25          liable in any civil action with respect to any report made

1 as required by this section, without knowledge of the fal-  
2 sity of the information contained in the report.

3 “(f) DEFINITIONS AND SPECIAL RULES.—For pur-  
4 poses of this section:

5 “(1) FINAL ADVERSE ACTION.—

6 “(A) IN GENERAL.—The term ‘final ad-  
7 verse action’ includes:

8 “(i) Civil judgments against a health  
9 care provider, supplier, or practitioner in  
10 Federal or State court related to the deliv-  
11 ery of a health care item or service.

12 “(ii) Federal or State criminal convic-  
13 tions related to the delivery of a health  
14 care item or service.

15 “(iii) Actions by Federal or State  
16 agencies responsible for the licensing and  
17 certification of health care providers, sup-  
18 pliers, and licensed health care practition-  
19 ers, including—

20 “(I) formal or official actions,  
21 such as revocation or suspension of a  
22 license (and the length of any such  
23 suspension), reprimand, censure or  
24 probation,

1 “(II) any other loss of license or  
2 the right to apply for, or renew, a li-  
3 cense of the provider, supplier, or  
4 practitioner, whether by operation of  
5 law, voluntary surrender, non-renew-  
6 ability, or otherwise, or

7 “(III) any other negative action  
8 or finding by such Federal or State  
9 agency that is publicly available infor-  
10 mation.

11 “(iv) Exclusion from participation in  
12 Federal or State health care programs.

13 “(v) Any other adjudicated actions or  
14 decisions that the Secretary shall establish  
15 by regulation.

16 “(B) EXCEPTION.—The term does not in-  
17 clude any action with respect to a malpractice  
18 claim.

19 “(2) PRACTITIONER.—The terms ‘licensed  
20 health care practitioner’, ‘licensed practitioner’, and  
21 ‘practitioner’ mean, with respect to a State, an indi-  
22 vidual who is licensed or otherwise authorized by the  
23 State to provide health care services (or any individ-  
24 ual who, without authority holds himself or herself  
25 out to be so licensed or authorized).



1           “(3) GOVERNMENT AGENCY.—The term ‘Gov-  
2       ernment agency’ shall include:

3           “(A) The Department of Justice.

4           “(B) The Department of Health and  
5       Human Services.

6           “(C) Any other Federal agency that either  
7       administers or provides payment for the deliv-  
8       ery of health care services, including, but not  
9       limited to the Department of Defense and the  
10      Veterans’ Administration.

11          “(D) State law enforcement agencies.

12          “(E) State medicaid fraud control units.

13          “(F) Federal or State agencies responsible  
14      for the licensing and certification of health care  
15      providers and licensed health care practitioners.

16          “(4) HEALTH PLAN.—The term ‘health plan’  
17      has the meaning given such term by section  
18      1128C(c).

19          “(5) DETERMINATION OF CONVICTION.—For  
20      purposes of paragraph (1), the existence of a convic-  
21      tion shall be determined under paragraph (4) of sec-  
22      tion 1128(i).”.

23      (b) IMPROVED PREVENTION IN ISSUANCE OF MEDI-  
24      CARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C.  
25      1395u(r)) is amended by adding at the end the following

1 new sentence: “Under such system, the Secretary may im-  
 2 pose appropriate fees on such physicians to cover the costs  
 3 of investigation and recertification activities with respect  
 4 to the issuance of the identifiers.”.

## 5                   **Subtitle D—Civil Monetary** 6                   **Penalties**

### 7   **SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PEN-** 8                   **ALTIES.**

9           (a) GENERAL CIVIL MONETARY PENALTIES.—Sec-  
 10 tion 1128A (42 U.S.C. 1320a–7a) is amended as follows:

11               (1) In the third sentence of subsection (a), by  
 12 striking “programs under title XVIII” and inserting  
 13 “Federal health care programs (as defined in section  
 14 1128B(f)(1))”.

15               (2) In subsection (f)—

16                       (A) by redesignating paragraph (3) as  
 17 paragraph (4); and

18                       (B) by inserting after paragraph (2) the  
 19 following new paragraph:

20               “(3) With respect to amounts recovered arising  
 21 out of a claim under a Federal health care program  
 22 (as defined in section 1128B(f)), the portion of such  
 23 amounts as is determined to have been paid by the  
 24 program shall be repaid to the program, and the  
 25 portion of such amounts attributable to the amounts

1 recovered under this section by reason of the amend-  
2 ments made by the Health Coverage Availability and  
3 Affordability Act of 1996 (as estimated by the Sec-  
4 retary) shall be deposited into the Federal Hospital  
5 Insurance Trust Fund pursuant to section  
6 1817(k)(2)(C).”.

7 (3) In subsection (i)—

8 (A) in paragraph (2), by striking “title V,  
9 XVIII, XIX, or XX of this Act” and inserting  
10 “a Federal health care program (as defined in  
11 section 1128B(f))”,

12 (B) in paragraph (4), by striking “a health  
13 insurance or medical services program under  
14 title XVIII or XIX of this Act” and inserting  
15 “a Federal health care program (as so de-  
16 fined)”, and

17 (C) in paragraph (5), by striking “title V,  
18 XVIII, XIX, or XX” and inserting “a Federal  
19 health care program (as so defined)”.

20 (4) By adding at the end the following new sub-  
21 section:

22 “(m)(1) For purposes of this section, with respect to  
23 a Federal health care program not contained in this Act,  
24 references to the Secretary in this section shall be deemed  
25 to be references to the Secretary or Administrator of the

1 department or agency with jurisdiction over such program  
2 and references to the Inspector General of the Department  
3 of Health and Human Services in this section shall be  
4 deemed to be references to the Inspector General of the  
5 applicable department or agency.

6 “(2)(A) The Secretary and Administrator of the de-  
7 partments and agencies referred to in paragraph (1) may  
8 include in any action pursuant to this section, claims with-  
9 in the jurisdiction of other Federal departments or agen-  
10 cies as long as the following conditions are satisfied:

11 “(i) The case involves primarily claims submit-  
12 ted to the Federal health care programs of the de-  
13 partment or agency initiating the action.

14 “(ii) The Secretary or Administrator of the de-  
15 partment or agency initiating the action gives notice  
16 and an opportunity to participate in the investiga-  
17 tion to the Inspector General of the department or  
18 agency with primary jurisdiction over the Federal  
19 health care programs to which the claims were sub-  
20 mitted.

21 “(B) If the conditions specified in subparagraph (A)  
22 are fulfilled, the Inspector General of the department or  
23 agency initiating the action is authorized to exercise all  
24 powers granted under the Inspector General Act of 1978  
25 with respect to the claims submitted to the other depart-

1 ments or agencies to the same manner and extent as pro-  
 2 vided in that Act with respect to claims submitted to such  
 3 departments or agencies.”.

4 (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP  
 5 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—

6 Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

7 (1) by striking “or” at the end of paragraph  
 8 (1)(D);

9 (2) by striking “, or” at the end of paragraph  
 10 (2) and inserting a semicolon;

11 (3) by striking the semicolon at the end of  
 12 paragraph (3) and inserting “; or”; and

13 (4) by inserting after paragraph (3) the follow-  
 14 ing new paragraph:

15 “(4) in the case of a person who is not an orga-  
 16 nization, agency, or other entity, is excluded from  
 17 participating in a program under title XVIII or a  
 18 State health care program in accordance with this  
 19 subsection or under section 1128 and who, at the  
 20 time of a violation of this subsection—

21 “(A) retains a direct or indirect ownership  
 22 or control interest in an entity that is partici-  
 23 pating in a program under title XVIII or a  
 24 State health care program, and who knows or

1           should know of the action constituting the basis  
2           for the exclusion; or

3           “(B) is an officer or managing employee  
4           (as defined in section 1126(b)) of such an en-  
5           tity;”.

6           (c) MODIFICATIONS OF AMOUNTS OF PENALTIES  
7   AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C.  
8   1320a–7a(a)), as amended by subsection (b), is amended  
9   in the matter following paragraph (4)—

10           (1) by striking “\$2,000” and inserting  
11           “\$10,000”;

12           (2) by inserting “; in cases under paragraph  
13           (4), \$10,000 for each day the prohibited relationship  
14           occurs” after “false or misleading information was  
15           given”; and

16           (3) by striking “twice the amount” and insert-  
17           ing “3 times the amount”.

18           (d) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-  
19   RECT CODING OR MEDICALLY UNNECESSARY SERV-  
20   ICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1))  
21   is amended—

22           (1) in subparagraph (A) by striking “claimed,”  
23           and inserting “claimed, including any person who  
24           engages in a pattern or practice of presenting or  
25           causing to be presented a claim for an item or serv-

1       ice that is based on a code that the person knows  
 2       or should know will result in a greater payment to  
 3       the person than the code the person knows or should  
 4       know is applicable to the item or service actually  
 5       provided,”;

6           (2) in subparagraph (C), by striking “or” at  
 7       the end; and

8           (3) by inserting after subparagraph (D) the fol-  
 9       lowing new subparagraph:

10           “(E) is for a medical or other item or serv-  
 11       ice that a person knows or should know is not  
 12       medically necessary; or”.

13       (e) SANCTIONS AGAINST PRACTITIONERS AND PER-  
 14       SONS FOR FAILURE TO COMPLY WITH STATUTORY OBLI-  
 15       GATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3))  
 16       is amended by striking “the actual or estimated cost” and  
 17       inserting “up to \$10,000 for each instance”.

18       (f) PROCEDURAL PROVISIONS.—Section 1876(i)(6)  
 19       (42 U.S.C. 1395mm(i)(6)), as amended by section  
 20       215(a)(2), is amended by adding at the end the following  
 21       new subparagraph:

22           “(D) The provisions of section 1128A (other than  
 23       subsections (a) and (b)) shall apply to a civil money pen-  
 24       alty under subparagraph (B)(i) or (C)(i) in the same man-

1 ner as such provisions apply to a civil money penalty or  
2 proceeding under section 1128A(a).”.

3 (g) PROHIBITION AGAINST OFFERING INDUCEMENTS  
4 TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR  
5 PLANS.—

6 (1) OFFER OF REMUNERATION.—Section  
7 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by  
8 subsection (b), is amended—

9 (A) by striking “or” at the end of para-  
10 graph (3);

11 (B) by striking the semicolon at the end of  
12 paragraph (4) and inserting “; or”; and

13 (D) by inserting after paragraph (4) the  
14 following new paragraph:

15 “(5) offers to or transfers remuneration to any  
16 individual eligible for benefits under title XVIII of  
17 this Act, or under a State health care program (as  
18 defined in section 1128(h)) that such person knows  
19 or should know is likely to influence such individual  
20 to order or receive from a particular provider, practi-  
21 tioner, or supplier any item or service for which pay-  
22 ment may be made, in whole or in part, under title  
23 XVIII, or a State health care program (as so de-  
24 fined);”.



1           (2)       REMUNERATION       DEFINED.—Section  
2       1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by  
3       adding at the end the following new paragraph:

4           “(6) The term ‘remuneration’ includes the waiv-  
5       er of coinsurance and deductible amounts (or any  
6       part thereof), and transfers of items or services for  
7       free or for other than fair market value. The term  
8       ‘remuneration’ does not include—

9           “(A) the waiver of coinsurance and deduct-  
10       ible amounts by a person, if—

11           “(i) the waiver is not offered as part  
12       of any advertisement or solicitation;

13           “(ii) the person does not routinely  
14       waive coinsurance or deductible amounts;  
15       and

16           “(iii) the person—

17           “(I) waives the coinsurance and  
18       deductible amounts after determining  
19       in good faith that the individual is in  
20       financial need;

21           “(II) fails to collect coinsurance  
22       or deductible amounts after making  
23       reasonable collection efforts; or

24           “(III) provides for any permis-  
25       sible waiver as specified in section

1 1128B(b)(3) or in regulations issued  
2 by the Secretary;

3 “(B) differentials in coinsurance and de-  
4 ductible amounts as part of a benefit plan de-  
5 sign as long as the differentials have been dis-  
6 closed in writing to all beneficiaries, third party  
7 payers, and providers, to whom claims are pre-  
8 sented and as long as the differentials meet the  
9 standards as defined in regulations promulgated  
10 by the Secretary not later than 180 days after  
11 the date of the enactment of the Health Cov-  
12 erage Availability and Affordability Act of  
13 1996; or

14 “(C) incentives given to individuals to pro-  
15 mote the delivery of preventive care as deter-  
16 mined by the Secretary in regulations so pro-  
17 mulgated.”.

18 (h) EFFECTIVE DATE.—The amendments made by  
19 this section shall take effect January 1, 1997.

20 **SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED**  
21 **FOR IMPOSITION OF SANCTIONS.**

22 (a) CLARIFICATION OF LEVEL OF KNOWLEDGE RE-  
23 QUIRED FOR IMPOSITION OF CIVIL MONETARY PEN-  
24 ALTIES.—

1           (1) IN GENERAL.—Section 1128A(a) (42  
2 U.S.C. 1320a–7a(a)) is amended—

3           (A) in paragraphs (1) and (2), by inserting  
4 “knowingly” before “presents” each place it ap-  
5 pears; and

6           (B) in paragraph (3), by striking “gives”  
7 and inserting “knowingly gives or causes to be  
8 given”.

9           (2) DEFINITION OF STANDARD.—Section  
10 1128A(i) (42 U.S.C. 1320a–7a(i)), as amended by  
11 section 231(g)(2), is amended by adding at the end  
12 the following new paragraph:

13           “(7) The term ‘should know’ means that a per-  
14 son, with respect to information—

15           “(A) acts in deliberate ignorance of the  
16 truth or falsity of the information; or

17           “(B) acts in reckless disregard of the truth  
18 or falsity of the information,

19 and no proof of specific intent to defraud is re-  
20 quired.”.

21           (b) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to acts or omissions occurring on  
23 or after January 1, 1997.

1 **SEC. 233. PENALTY FOR FALSE CERTIFICATION FOR HOME**  
2 **HEALTH SERVICES.**

3 (a) IN GENERAL.—Section 1128A(b) (42 U.S.C.  
4 1320a–7a(b)) is amended by adding at the end the follow-  
5 ing new paragraph:

6 “(3)(A) Any physician who executes a document de-  
7 scribed in subparagraph (B) with respect to an individual  
8 knowing that all of the requirements referred to in such  
9 subparagraph are not met with respect to the individual  
10 shall be subject to a civil monetary penalty of not more  
11 than the greater of—

12 “(i) \$5,000, or

13 “(ii) three times the amount of the payments  
14 under title XVIII for home health services which are  
15 made pursuant to such certification.

16 “(B) A document described in this subparagraph is  
17 any document that certifies, for purposes of title XVIII,  
18 that an individual meets the requirements of section  
19 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home  
20 health services furnished to the individual.”.

21 (b) EFFECTIVE DATE.—The amendment made by  
22 subsection (a) shall apply to certifications made on or  
23 after the date of the enactment of this Act.

1     **Subtitle E—Revisions to Criminal**  
2                             **Law**

3     **SEC. 241. DEFINITIONS RELATING TO FEDERAL HEALTH**  
4                             **CARE OFFENSE.**

5             (a) IN GENERAL.—Chapter 1 of title 18, United  
6 States Code, is amended by adding at the end the follow-  
7 ing:

8     **“§ 24. Definitions relating to Federal health care of-**  
9                             **fense**

10            “(a) As used in this title, the term ‘Federal health  
11 care offense’ means a violation of, or a criminal conspiracy  
12 to violate—

13               “(1) section 669, 1035, 1347, or 1518 of this  
14 title; or

15               “(2) section 287, 371, 664, 666, 1001, 1027,  
16 1341, 1343, or 1954 of this title, if the violation or  
17 conspiracy relates to a health care benefit program.

18            “(b) As used in this title, the term ‘health care bene-  
19 fit program’ means any public or private plan or contract,  
20 affecting commerce, under which any medical benefit,  
21 item, or service is provided to any individual, and includes  
22 any individual or entity who is providing a medical benefit,  
23 item, or service for which payment may be made under  
24 the plan or contract.”.

1 (b) CLERICAL AMENDMENT.—The table of sections  
 2 at the beginning of chapter 2 of title 18, United States  
 3 Code, is amended by inserting after the item relating to  
 4 section 23 the following new item:

“24. Definitions relating to Federal health care offense.”.

5 **SEC. 242. HEALTH CARE FRAUD.**

6 (a) OFFENSE.—

7 (1) IN GENERAL.—Chapter 63 of title 18, Unit-  
 8 ed States Code, is amended by adding at the end the  
 9 following:

10 **“§ 1347. Health care fraud**

11 “Whoever knowingly executes, or attempts to execute,  
 12 a scheme or artifice—

13 “(1) to defraud any health care benefit pro-  
 14 gram; or

15 “(2) to obtain, by means of false or fraudulent  
 16 pretenses, representations, or promises, any of the  
 17 money or property owned by, or under the custody  
 18 or control of, any health care benefit program,

19 in connection with the delivery of or payment for health  
 20 care benefits, items, or services, shall be fined under this  
 21 title or imprisoned not more than 10 years, or both. If  
 22 the violation results in serious bodily injury (as defined  
 23 in section 1365 of this title), such person shall be fined  
 24 under this title or imprisoned not more than 20 years, or  
 25 both; and if the violation results in death, such person

1 shall be fined under this title, or imprisoned for any term  
2 of years or for life, or both.”.

3 (2) CLERICAL AMENDMENT.—The table of sec-  
4 tions at the beginning of chapter 63 of title 18,  
5 United States Code, is amended by adding at the  
6 end the following:

“1347. Health care fraud.”.

7 (b) CRIMINAL FINES DEPOSITED IN FEDERAL HOS-  
8 PITAL INSURANCE TRUST FUND.—The Secretary of the  
9 Treasury shall deposit into the Federal Hospital Insurance  
10 Trust Fund pursuant to section 1817(k)(2)(C) of the So-  
11 cial Security Act (42 U.S.C. 1395i) an amount equal to  
12 the criminal fines imposed under section 1347 of title 18,  
13 United States Code (relating to health care fraud).

14 **SEC. 243. THEFT OR EMBEZZLEMENT.**

15 (a) IN GENERAL.—Chapter 31 of title 18, United  
16 States Code, is amended by adding at the end the follow-  
17 ing:

18 **“§ 669. Theft or embezzlement in connection with**  
19 **health care**

20 “(a) Whoever embezzles, steals, or otherwise without  
21 authority knowingly converts to the use of any person  
22 other than the rightful owner, or intentionally misapplies  
23 any of the moneys, funds, securities, premiums, credits,  
24 property, or other assets of a health care benefit program,  
25 shall be fined under this title or imprisoned not more than

1 10 years, or both; but if the value of such property does  
 2 not exceed the sum of \$100 the defendant shall be fined  
 3 under this title or imprisoned not more than one year, or  
 4 both.

5 “(b) As used in this section, the term ‘health care  
 6 benefit program’ has the meaning given such term in sec-  
 7 tion 1347(b) of this title.”.

8 (b) CLERICAL AMENDMENT.—The table of sections  
 9 at the beginning of chapter 31 of title 18, United States  
 10 Code, is amended by adding at the end the following:

“669. Theft or embezzlement in connection with health care.”.

11 **SEC. 244. FALSE STATEMENTS.**

12 (a) IN GENERAL.—Chapter 47 of title 18, United  
 13 States Code, is amended by adding at the end the follow-  
 14 ing:

15 **“§ 1035. False statements relating to health care mat-**  
 16 **ters**

17 “(a) Whoever, in any matter involving a health care  
 18 benefit program, knowingly—

19 “(1) falsifies, conceals, or covers up by any  
 20 trick, scheme, or device a material fact; or

21 “(2) makes any false, fictitious, or fraudulent  
 22 statements or representations, or makes or uses any  
 23 false writing or document knowing the same to con-  
 24 tain any false, fictitious, or fraudulent statement or  
 25 entry,



1 in connection with the delivery of or payment for health  
 2 care benefits, items, or services, shall be fined under this  
 3 title or imprisoned not more than 5 years, or both.

4 “(b) As used in this section, the term ‘health care  
 5 benefit program’ has the meaning given such term in sec-  
 6 tion 1347(b) of this title.”.

7 (b) CLERICAL AMENDMENT.—The table of sections  
 8 at the beginning of chapter 47 of title 18, United States  
 9 Code, is amended by adding at the end the following new  
 10 item:

“1035. False statements relating to health care matters.”.

11 **SEC. 245. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF**  
 12 **HEALTH CARE OFFENSES.**

13 (a) IN GENERAL.—Chapter 73 of title 18, United  
 14 States Code, is amended by adding at the end the follow-  
 15 ing:

16 **“§ 1518. Obstruction of criminal investigations of**  
 17 **health care offenses**

18 “(a) Whoever willfully prevents, obstructs, misleads,  
 19 delays or attempts to prevent, obstruct, mislead, or delay  
 20 the communication of information or records relating to  
 21 a violation of a Federal health care offense to a criminal  
 22 investigator shall be fined under this title or imprisoned  
 23 not more than 5 years, or both.

24 “(b) As used in this section the term ‘criminal inves-  
 25 tigator’ means any individual duly authorized by a depart-

1 ment, agency, or armed force of the United States to con-  
 2 duct or engage in investigations for prosecutions for viola-  
 3 tions of health care offenses.”.

4 (b) CLERICAL AMENDMENT.—The table of sections  
 5 at the beginning of chapter 73 of title 18, United States  
 6 Code, is amended by adding at the end the following new  
 7 item:

“1518. Obstruction of criminal investigations of health care offenses.”.

8 **SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.**

9 Section 1956(c)(7) of title 18, United States Code,  
 10 is amended by adding at the end the following:

11 “(F) Any act or activity constituting an of-  
 12 fense involving a Federal health care offense.”.

13 **SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE**  
 14 **OFFENSES.**

15 (a) IN GENERAL.—Section 1345(a)(1) of title 18,  
 16 United States Code, is amended—

17 (1) by striking “or” at the end of subparagraph  
 18 (A);

19 (2) by inserting “or” at the end of subpara-  
 20 graph (B); and

21 (3) by adding at the end the following:

22 “(C) committing or about to commit a Federal  
 23 health care offense.”.

1 (b) FREEZING OF ASSETS.—Section 1345(a)(2) of  
2 title 18, United States Code, is amended by inserting “or  
3 a Federal health care offense” after “title”).

4 **SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCE-**  
5 **DURES.**

6 (a) IN GENERAL.—Chapter 223 of title 18, United  
7 States Code, is amended by adding after section 3485 the  
8 following:

9 **“§ 3486. Authorized investigative demand procedures**

10 “(a) AUTHORIZATION.—In any investigation relating  
11 to any act or activity involving a Federal health care of-  
12 fense, the Attorney General or the Attorney General’s des-  
13 ignee may issue in writing and cause to be served a sub-  
14 poena requiring the production of any records (including  
15 any books, papers, documents, electronic media, or other  
16 objects or tangible things), which may be relevant to an  
17 authorized law enforcement inquiry, that a person or legal  
18 entity may possess or have care, custody, or control. A  
19 subpoena shall describe the objects required to be pro-  
20 duced and prescribe a return date within a reasonable pe-  
21 riod of time within which the objects can be assembled  
22 and made available.

23 “(b) SERVICE.—A subpoena issued under this section  
24 may be served by any person designated in the subpoena  
25 to serve it. Service upon a natural person may be made

1 by personal delivery of the subpoena to him. Service may  
2 be made upon a domestic or foreign corporation or upon  
3 a partnership or other unincorporated association which  
4 is subject to suit under a common name, by delivering the  
5 subpoena to an officer, to a managing or general agent,  
6 or to any other agent authorized by appointment or by  
7 law to receive service of process. The affidavit of the per-  
8 son serving the subpoena entered on a true copy thereof  
9 by the person serving it shall be proof of service.

10 “(c) ENFORCEMENT.—In the case of contumacy by  
11 or refusal to obey a subpoena issued to any person, the  
12 Attorney General may invoke the aid of any court of the  
13 United States within the jurisdiction of which the inves-  
14 tigation is carried on or of which the subpoenaed person  
15 is an inhabitant, or in which he carries on business or may  
16 be found, to compel compliance with the subpoena. The  
17 court may issue an order requiring the subpoenaed person  
18 to appear before the Attorney General to produce records,  
19 if so ordered, or to give testimony touching the matter  
20 under investigation. Any failure to obey the order of the  
21 court may be punished by the court as a contempt thereof.  
22 All process in any such case may be served in any judicial  
23 district in which such person may be found.

24 “(d) IMMUNITY FROM CIVIL LIABILITY.—Notwith-  
25 standing any Federal, State, or local law, any person, in-

1 cluding officers, agents, and employees, receiving a sum-  
2 mons under this section, who complies in good faith with  
3 the summons and thus produces the materials sought,  
4 shall not be liable in any court of any State or the United  
5 States to any customer or other person for such produc-  
6 tion or for nondisclosure of that production to the cus-  
7 tomer.

8       “(e) LIMITATION ON USE.—(1) Health information  
9 about an individual that is disclosed under this section  
10 may not be used in, or disclosed to any person for use  
11 in, any administrative, civil, or criminal action or inves-  
12 tigation directed against the individual who is the subject  
13 of the information unless the action or investigation arises  
14 out of and is directly related to receipt of health care or  
15 payment for health care or action involving a fraudulent  
16 claim related to health; or if authorized by an appropriate  
17 order of a court of competent jurisdiction, granted after  
18 application showing good cause therefor.

19       “(2) In assessing good cause, the court shall weigh  
20 the public interest and the need for disclosure against the  
21 injury to the patient, to the physician-patient relationship,  
22 and to the treatment services.

23       “(3) Upon the granting of such order, the court, in  
24 determining the extent to which any disclosure of all or

1 any part of any record is necessary, shall impose appropriate  
 2 safeguards against unauthorized disclosure.”.

3 (b) CLERICAL AMENDMENT.—The table of sections  
 4 at the beginning of chapter 223 of title 18, United States  
 5 Code, is amended by inserting after the item relating to  
 6 section 3485 the following new item:

“3486. Authorized investigative demand procedures.”.

7 (c) CONFORMING AMENDMENT.—Section  
 8 1510(b)(3)(B) of title 18, United States Code, is amended  
 9 by inserting “or a Department of Justice subpoena (issued  
 10 under section 3486 of title 18),” after “subpoena”.

11 **SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OF-**  
 12 **FENSES.**

13 (a) IN GENERAL.—Section 982(a) of title 18, United  
 14 States Code, is amended by adding after paragraph (5)  
 15 the following new paragraph:

16 “(6) The court, in imposing sentence on a person con-  
 17 victed of a Federal health care offense, shall order the per-  
 18 son to forfeit property, real or personal, that constitutes  
 19 or is derived, directly or indirectly, from gross proceeds  
 20 traceable to the commission of the offense.”.

21 (b) CONFORMING AMENDMENT.—Section  
 22 982(b)(1)(A) of title 18, United States Code, is amended  
 23 by inserting “or (a)(6)” after “(a)(1)”.

24 (c) PROPERTY FORFEITED DEPOSITED IN FEDERAL  
 25 HOSPITAL INSURANCE TRUST FUND.—

1           (1) IN GENERAL.—After the payment of the  
2           costs of asset forfeiture has been made, and notwith-  
3           standing any other provision of law, the Secretary of  
4           the Treasury shall deposit into the Federal Hospital  
5           Insurance Trust Fund pursuant to section  
6           1817(k)(2)(C) of the Social Security Act, as added  
7           by section 301(b), an amount equal to the net  
8           amount realized from the forfeiture of property by  
9           reason of a Federal health care offense pursuant to  
10          section 982(a)(6) of title 18, United States Code.

11          (2) COSTS OF ASSET FORFEITURE.—For pur-  
12          poses of paragraph (1), the term “payment of the  
13          costs of asset forfeiture” means—

14                (A) the payment, at the discretion of the  
15                Attorney General, of any expenses necessary to  
16                seize, detain, inventory, safeguard, maintain,  
17                advertise, sell, or dispose of property under sei-  
18                zure, detention, or forfeited, or of any other  
19                necessary expenses incident to the seizure, de-  
20                tention, forfeiture, or disposal of such property,  
21                including payment for—

22                       (i) contract services;

23                       (ii) the employment of outside con-  
24                       tractors to operate and manage properties  
25                       or provide other specialized services nec-

1            necessary to dispose of such properties in an  
2            effort to maximize the return from such  
3            properties; and

4            (iii) reimbursement of any Federal,  
5            State, or local agency for any expenditures  
6            made to perform the functions described in  
7            this subparagraph;

8            (B) at the discretion of the Attorney Gen-  
9            eral, the payment of awards for information or  
10          assistance leading to a civil or criminal forfeit-  
11          ure involving any Federal agency participating  
12          in the Health Care Fraud and Abuse Control  
13          Account;

14          (C) the compromise and payment of valid  
15          liens and mortgages against property that has  
16          been forfeited, subject to the discretion of the  
17          Attorney General to determine the validity of  
18          any such lien or mortgage and the amount of  
19          payment to be made, and the employment of at-  
20          torneys and other personnel skilled in State real  
21          estate law as necessary;

22          (D) payment authorized in connection with  
23          remission or mitigation procedures relating to  
24          property forfeited; and



1           (E) the payment of State and local prop-  
2           erty taxes on forfeited real property that ac-  
3           crued between the date of the violation giving  
4           rise to the forfeiture and the date of the forfeit-  
5           ure order.

6 **SEC. 250. RELATION TO ERISA AUTHORITY.**

7           Nothing in this subtitle shall be construed as affect-  
8           ing the authority of the Secretary of Labor under section  
9           506(b) of the Employee Retirement Income Security Act  
10          of 1974, including the Secretary's authority with respect  
11          to violations of title 18, United States Code (as amended  
12          by this subtitle).

13                   **Subtitle F—Administrative**  
14                   **Simplification**

15 **SEC. 251. PURPOSE.**

16          It is the purpose of this subtitle to improve the medi-  
17          care program under title XVIII of the Social Security Act,  
18          the medicaid program under title XIX of such Act, and  
19          the efficiency and effectiveness of the health care system,  
20          by encouraging the development of a health information  
21          system through the establishment of standards and re-  
22          quirements for the electronic transmission of certain  
23          health information.

1 **SEC. 252. ADMINISTRATIVE SIMPLIFICATION.**

2 (a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.)  
3 is amended by adding at the end the following:

4 “PART C—ADMINISTRATIVE SIMPLIFICATION

5 “DEFINITIONS

6 “SEC. 1171. For purposes of this part:

7 “(1) CLEARINGHOUSE.—The term ‘clearing-  
8 house’ means a public or private entity that proc-  
9 esses or facilitates the processing of nonstandard  
10 data elements of health information into standard  
11 data elements.

12 “(2) CODE SET.—The term ‘code set’ means  
13 any set of codes used for encoding data elements,  
14 such as tables of terms, medical concepts, medical  
15 diagnostic codes, or medical procedure codes.

16 “(3) HEALTH CARE PROVIDER.—The term  
17 ‘health care provider’ includes a provider of services  
18 (as defined in section 1861(u)), a provider of medi-  
19 cal or other health services (as defined in section  
20 1861(s)), and any other person furnishing health  
21 care services or supplies.

22 “(4) HEALTH INFORMATION.—The term ‘health  
23 information’ means any information, whether oral or  
24 recorded in any form or medium that—

25 “(A) is created or received by a health care  
26 provider, health plan, public health authority,

1 employer, life insurer, school or university, or  
2 clearinghouse; and

3 “(B) relates to the past, present, or future  
4 physical or mental health or condition of an in-  
5 dividual, the provision of health care to an indi-  
6 vidual, or the past, present, or future payment  
7 for the provision of health care to an individual.

8 “(5) HEALTH PLAN.—The term ‘health plan’  
9 means a plan which provides, or pays the cost of,  
10 health benefits. Such term includes the following,  
11 and any combination thereof:

12 “(A) Part A or part B of the medicare  
13 program under title XVIII.

14 “(B) The medicaid program under title  
15 XIX.

16 “(C) A medicare supplemental policy (as  
17 defined in section 1882(g)(1)).

18 “(D) A long-term care policy, including a  
19 nursing home fixed indemnity policy (unless the  
20 Secretary determines that such a policy does  
21 not provide sufficiently comprehensive coverage  
22 of a benefit so that the policy should be treated  
23 as a health plan).

24 “(E) Health benefits of an employee wel-  
25 fare benefit plan, as defined in section 3(1) of

1 the Employee Retirement Income Security Act  
2 of 1974 (29 U.S.C. 1002(1)), but only to the  
3 extent the plan is established or maintained for  
4 the purpose of providing health benefits and  
5 has 50 or more participants (as defined in sec-  
6 tion 3(7) of such Act).

7 “(F) An employee welfare benefit plan or  
8 any other arrangement which is established or  
9 maintained for the purpose of offering or pro-  
10 viding health benefits to the employees of 2 or  
11 more employers.

12 “(G) The health care program for active  
13 military personnel under title 10, United States  
14 Code.

15 “(H) The veterans health care program  
16 under chapter 17 of title 38, United States  
17 Code.

18 “(I) The Civilian Health and Medical Pro-  
19 gram of the Uniformed Services (CHAMPUS),  
20 as defined in section 1073(4) of title 10, United  
21 States Code.

22 “(J) The Indian health service program  
23 under the Indian Health Care Improvement Act  
24 (25 U.S.C. 1601 et seq.).

1           “(K) The Federal Employees Health Bene-  
2           fit Plan under chapter 89 of title 5, United  
3           States Code.

4           “(6) INDIVIDUALLY IDENTIFIABLE HEALTH IN-  
5           FORMATION.—The term ‘individually identifiable  
6           health information’ means any information, includ-  
7           ing demographic information collected from an indi-  
8           vidual, that—

9           “(A) is created or received by a health care  
10          provider, health plan, employer, or clearing-  
11          house; and

12          “(B) relates to the past, present, or future  
13          physical or mental health or condition of an in-  
14          dividual, the provision of health care to an indi-  
15          vidual, or the past, present, or future payment  
16          for the provision of health care to an individual,  
17          and—

18          “(i) identifies the individual; or

19          “(ii) with respect to which there is a  
20          reasonable basis to believe that the infor-  
21          mation can be used to identify the individ-  
22          ual.

23          “(7) STANDARD.—The term ‘standard’, when  
24          used with reference to a data element of health in-  
25          formation or a transaction referred to in section

1 1173(a)(1), means any such data element or trans-  
2 action that meets each of the standards and imple-  
3 mentation specifications adopted or established by  
4 the Secretary with respect to the data element or  
5 transaction under sections 1172 through 1174.

6 “(8) STANDARD SETTING ORGANIZATION.—The  
7 term ‘standard setting organization’ means a stand-  
8 ard setting organization accredited by the American  
9 National Standards Institute, including the National  
10 Council for Prescription Drug Programs, that devel-  
11 ops standards for information transactions, data ele-  
12 ments, or any other standard that is necessary to,  
13 or will facilitate, the implementation of this part.

14 “GENERAL REQUIREMENTS FOR ADOPTION OF  
15 STANDARDS

16 “SEC. 1172. (a) APPLICABILITY.—Any standard  
17 adopted under this part shall apply, in whole or in part,  
18 to the following persons:

19 “(1) A health plan.

20 “(2) A clearinghouse.

21 “(3) A health care provider who transmits any  
22 health information in electronic form in connection  
23 with a transaction referred to in section 1173(a)(1).

24 “(b) REDUCTION OF COSTS.—Any standard adopted  
25 under this part shall be consistent with the objective of

1 reducing the administrative costs of providing and paying  
2 for health care.

3 “(c) ROLE OF STANDARD SETTING ORGANIZA-  
4 TIONS.—

5 “(1) IN GENERAL.—Except as provided in para-  
6 graph (2), any standard adopted under this part  
7 shall be a standard that has been developed, adopt-  
8 ed, or modified by a standard setting organization.

9 “(2) SPECIAL RULES.—

10 “(A) DIFFERENT STANDARDS.—The Sec-  
11 retary may adopt a standard that is different  
12 from any standard developed, adopted, or modi-  
13 fied by a standard setting organization, if—

14 “(i) the different standard will sub-  
15 stantially reduce administrative costs to  
16 health care providers and health plans  
17 compared to the alternatives; and

18 “(ii) the standard is promulgated in  
19 accordance with the rulemaking procedures  
20 of subchapter III of chapter 5 of title 5,  
21 United States Code.

22 “(B) NO STANDARD BY STANDARD SET-  
23 TING ORGANIZATION.—If no standard setting  
24 organization has developed, adopted, or modi-  
25 fied any standard relating to a standard that

1           the Secretary is authorized or required to adopt  
2           under this part—

3                   “(i) paragraph (1) shall not apply;  
4                   and

5                   “(ii) subsection (f) shall apply.

6           “(d) IMPLEMENTATION SPECIFICATIONS.—The Sec-  
7   retary shall establish specifications for implementing each  
8   of the standards adopted under this part.

9           “(e) PROTECTION OF TRADE SECRETS.—Except as  
10   otherwise required by law, a standard adopted under this  
11   part shall not require disclosure of trade secrets or con-  
12   fidential commercial information by a person required to  
13   comply with this part.

14          “(f) ASSISTANCE TO THE SECRETARY.—In complying  
15   with the requirements of this part, the Secretary shall rely  
16   on the recommendations of the National Committee on  
17   Vital and Health Statistics established under section  
18   306(k) of the Public Health Service Act (42 U.S.C.  
19   242k(k)) and shall consult with appropriate Federal and  
20   State agencies and private organizations. The Secretary  
21   shall publish in the Federal Register any recommendation  
22   of the National Committee on Vital and Health Statistics  
23   regarding the adoption of a standard under this part.

24          “(g) APPLICATION TO MODIFICATIONS OF STAND-  
25   ARDS.—This section shall apply to a modification to a



1 standard (including an addition to a standard) adopted  
2 under section 1174(b) in the same manner as it applies  
3 to an initial standard adopted under section 1174(a).

4 “STANDARDS FOR INFORMATION TRANSACTIONS AND  
5 DATA ELEMENTS

6 “SEC. 1173. (a) STANDARDS TO ENABLE ELEC-  
7 TRONIC EXCHANGE.—

8 “(1) IN GENERAL.—The Secretary shall adopt  
9 standards for transactions, and data elements for  
10 such transactions, to enable health information to be  
11 exchanged electronically, that are appropriate for—

12 “(A) the financial and administrative  
13 transactions described in paragraph (2); and

14 “(B) other financial and administrative  
15 transactions determined appropriate by the Sec-  
16 retary consistent with the goals of improving  
17 the operation of the health care system and re-  
18 ducing administrative costs.

19 “(2) TRANSACTIONS.—The transactions re-  
20 ferred to in paragraph (1)(A) are the following:

21 “(A) Claims (including coordination of  
22 benefits) or equivalent encounter information.

23 “(B) Claims attachments.

24 “(C) Enrollment and disenrollment.

25 “(D) Eligibility.

1                   “(E) Health care payment and remittance  
2                   advice.

3                   “(F) Premium payments.

4                   “(G) First report of injury.

5                   “(H) Claims status.

6                   “(I) Referral certification and authoriza-  
7                   tion.

8                   “(3) ACCOMMODATION OF SPECIFIC PROVID-  
9                   ERS.—The standards adopted by the Secretary  
10                  under paragraph (1) shall accommodate the needs of  
11                  different types of health care providers.

12                  “(b) UNIQUE HEALTH IDENTIFIERS.—

13                   “(1) IN GENERAL.—The Secretary shall adopt  
14                   standards providing for a standard unique health  
15                   identifier for each individual, employer, health plan,  
16                   and health care provider for use in the health care  
17                   system. In carrying out the preceding sentence for  
18                   each health plan and health care provider, the Sec-  
19                   retary shall take into account multiple uses for iden-  
20                   tifiers and multiple locations and specialty classifica-  
21                   tions for health care providers.

22                   “(2) USE OF IDENTIFIERS.—The standards  
23                   adopted under paragraphs (1) shall specify the pur-  
24                   poses for which a unique health identifier may be  
25                   used.

1 “(c) CODE SETS.—

2 “(1) IN GENERAL.—The Secretary shall adopt  
3 standards that—

4 “(A) select code sets for appropriate data  
5 elements for the transactions referred to in sub-  
6 section (a)(1) from among the code sets that  
7 have been developed by private and public enti-  
8 ties; or

9 “(B) establish code sets for such data ele-  
10 ments if no code sets for the data elements  
11 have been developed.

12 “(2) DISTRIBUTION.—The Secretary shall es-  
13 tablish efficient and low-cost procedures for distribu-  
14 tion (including electronic distribution) of code sets  
15 and modifications made to such code sets under sec-  
16 tion 1174(b).

17 “(d) SECURITY STANDARDS FOR HEALTH INFORMA-  
18 TION.—

19 “(1) SECURITY STANDARDS.—The Secretary  
20 shall adopt security standards that—

21 “(A) take into account—

22 “(i) the technical capabilities of record  
23 systems used to maintain health informa-  
24 tion;

25 “(ii) the costs of security measures;

1                   “(iii) the need for training persons  
2                   who have access to health information;

3                   “(iv) the value of audit trails in com-  
4                   puterized record systems; and

5                   “(v) the needs and capabilities of  
6                   small health care providers and rural  
7                   health care providers (as such providers  
8                   are defined by the Secretary); and

9                   “(B) ensure that a clearinghouse, if it is  
10                  part of a larger organization, has policies and  
11                  security procedures which isolate the activities  
12                  of the clearinghouse with respect to processing  
13                  information in a manner that prevents unau-  
14                  thorized access to such information by such  
15                  larger organization.

16                  “(2) SAFEGUARDS.—Each person described in  
17                  section 1172(a) who maintains or transmits health  
18                  information shall maintain reasonable and appro-  
19                  priate administrative, technical, and physical safe-  
20                  guards—

21                         “(A) to ensure the integrity and confiden-  
22                         tiality of the information;

23                         “(B) to protect against any reasonably an-  
24                         ticipated—

1 “(i) threats or hazards to the security  
2 or integrity of the information; and

3 “(ii) unauthorized uses or disclosures  
4 of the information; and

5 “(C) otherwise to ensure compliance with  
6 this part by the officers and employees of such  
7 person.

8 “(e) PRIVACY STANDARDS FOR HEALTH INFORMA-  
9 TION.—The Secretary shall adopt standards with respect  
10 to the privacy of individually identifiable health informa-  
11 tion transmitted in connection with the transactions re-  
12 ferred to in subsection (a)(1). Such standards shall in-  
13 clude standards concerning at least the following:

14 “(1) The rights of an individual who is a sub-  
15 ject of such information.

16 “(2) The procedures to be established for the  
17 exercise of such rights.

18 “(3) The uses and disclosures of such informa-  
19 tion that are authorized or required.

20 “(f) ELECTRONIC SIGNATURE.—

21 “(1) IN GENERAL.—

22 “(A) STANDARDS.—The Secretary, in co-  
23 ordination with the Secretary of Commerce,  
24 shall adopt standards specifying procedures for  
25 the electronic transmission and authentication

1 of signatures with respect to the transactions  
2 referred to in subsection (a)(1).

3 “(B) EFFECT OF COMPLIANCE.—Compli-  
4 ance with the standards adopted under sub-  
5 paragraph (A) shall be deemed to satisfy Fed-  
6 eral and State statutory requirements for writ-  
7 ten signatures with respect to the transactions  
8 referred to in subsection (a)(1).

9 “(2) PAYMENTS FOR SERVICES AND PRE-  
10 MIUMS.—Nothing in this part shall be construed to  
11 prohibit payment for health care services or insur-  
12 ance plan premiums by debit, credit, payment card  
13 or numbers, or other electronic means.

14 “(g) TRANSFER OF INFORMATION AMONG HEALTH  
15 PLANS.—The Secretary shall adopt standards for trans-  
16 ferring among health plans appropriate standard data ele-  
17 ments needed for the coordination of benefits, the sequen-  
18 tial processing of claims, and other data elements for indi-  
19 viduals who have more than one health plan.

20 “TIMETABLES FOR ADOPTION OF STANDARDS

21 “SEC. 1174. (a) INITIAL STANDARDS.—The Sec-  
22 retary shall carry out section 1173 not later than 18  
23 months after the date of the enactment of the Health Cov-  
24 erage Availability and Affordability Act of 1996, except  
25 that standards relating to claims attachments shall be  
26 adopted not later than 30 months after such date.

1       “(b) ADDITIONS AND MODIFICATIONS TO STAND-  
2 ARDS.—

3               “(1) IN GENERAL.—Except as provided in para-  
4 graph (2), the Secretary shall review the standards  
5 adopted under section 1173, and shall adopt modi-  
6 fications to the standards (including additions to the  
7 standards), as determined appropriate, but not more  
8 frequently than once every 6 months. Any addition  
9 or modification to a standard shall be completed in  
10 a manner which minimizes the disruption and cost  
11 of compliance.

12              “(2) SPECIAL RULES.—

13                   “(A) FIRST 12-MONTH PERIOD.—Except  
14 with respect to additions and modifications to  
15 code sets under subparagraph (B), the Sec-  
16 retary may not adopt any modification to a  
17 standard adopted under this part during the  
18 12-month period beginning on the date the  
19 standard is initially adopted, unless the Sec-  
20 retary determines that the modification is nec-  
21 essary in order to permit compliance with the  
22 standard.

23                   “(B) ADDITIONS AND MODIFICATIONS TO  
24 CODE SETS.—

1                   “(i) IN GENERAL.—The Secretary  
2                   shall ensure that procedures exist for the  
3                   routine maintenance, testing, enhancement,  
4                   and expansion of code sets.

5                   “(ii) ADDITIONAL RULES.—If a code  
6                   set is modified under this subsection, the  
7                   modified code set shall include instructions  
8                   on how data elements of health informa-  
9                   tion that were encoded prior to the modi-  
10                  fication may be converted or translated so  
11                  as to preserve the informational value of  
12                  the data elements that existed before the  
13                  modification. Any modification to a code  
14                  set under this subsection shall be imple-  
15                  mented in a manner that minimizes the  
16                  disruption and cost of complying with such  
17                  modification.

18                   “REQUIREMENTS

19                  “SEC. 1175. (a) CONDUCT OF TRANSACTIONS BY  
20                  PLANS.—

21                   “(1) IN GENERAL.—If a person desires to con-  
22                  duct a transaction referred to in section 1173(a)(1)  
23                  with a health plan as a standard transaction—

24                   “(A) the health plan may not refuse to  
25                  conduct such transaction as a standard trans-  
26                  action;



1           “(B) the insurance plan may not delay  
2           such transaction, or otherwise adversely affect,  
3           or attempt to adversely affect, the person or the  
4           transaction on the ground that the transaction  
5           is a standard transaction; and

6           “(C) the information transmitted and re-  
7           ceived in connection with the transaction shall  
8           be in the form of standard data elements of  
9           health information.

10          “(2) SATISFACTION OF REQUIREMENTS.—A  
11          health plan may satisfy the requirements under  
12          paragraph (1) by—

13               “(A) directly transmitting and receiving  
14               standard data elements of health information;  
15               or

16               “(B) submitting nonstandard data ele-  
17               ments to a clearinghouse for processing into  
18               standard data elements and transmission by the  
19               clearinghouse, and receiving standard data ele-  
20               ments through the clearinghouse.

21          “(3) TIMETABLE FOR COMPLIANCE.—Para-  
22          graph (1) shall not be construed to require a health  
23          plan to comply with any standard, implementation  
24          specification, or modification to a standard or speci-  
25          fication adopted or established by the Secretary

1 under sections 1172 through 1174 at any time prior  
2 to the date on which the plan is required to comply  
3 with the standard or specification under subsection  
4 (b).

5 “(b) COMPLIANCE WITH STANDARDS.—

6 “(1) INITIAL COMPLIANCE.—

7 “(A) IN GENERAL.—Not later than 24  
8 months after the date on which an initial stand-  
9 ard or implementation specification is adopted  
10 or established under sections 1172 and 1173,  
11 each person to whom the standard or imple-  
12 mentation specification applies shall comply  
13 with the standard or specification.

14 “(B) SPECIAL RULE FOR SMALL HEALTH  
15 PLANS.—In the case of a small health plan,  
16 paragraph (1) shall be applied by substituting  
17 ‘36 months’ for ‘24 months’. For purposes of  
18 this subsection, the Secretary shall determine  
19 the plans that qualify as small health plans.

20 “(2) COMPLIANCE WITH MODIFIED STAND-  
21 ARDS.—If the Secretary adopts a modification to a  
22 standard or implementation specification under this  
23 part, each person to whom the standard or imple-  
24 mentation specification applies shall comply with the  
25 modified standard or implementation specification at

1 such time as the Secretary determines appropriate,  
2 taking into account the time needed to comply due  
3 to the nature and extent of the modification. The  
4 time determined appropriate under the preceding  
5 sentence may not be earlier than the last day of the  
6 180-day period beginning on the date such modifica-  
7 tion is adopted. The Secretary may extend the time  
8 for compliance for small health plans, if the Sec-  
9 retary determines that such extension is appropriate.

10 “GENERAL PENALTY FOR FAILURE TO COMPLY WITH  
11 REQUIREMENTS AND STANDARDS

12 “SEC. 1176. (a) GENERAL PENALTY.—

13 “(1) IN GENERAL.—Except as provided in sub-  
14 section (b), the Secretary shall impose on any person  
15 who violates a provision of this part a penalty of not  
16 more than \$100 for each such violation, except that  
17 the total amount imposed on the person for all viola-  
18 tions of an identical requirement or prohibition dur-  
19 ing a calendar year may not exceed \$25,000.

20 “(2) PROCEDURES.—The provisions of section  
21 1128A (other than subsections (a) and (b) and the  
22 second sentence of subsection (f)) shall apply to the  
23 imposition of a civil money penalty under this sub-  
24 section in the same manner as such provisions apply  
25 to the imposition of a penalty under such section  
26 1128A.

1 “(b) LIMITATIONS.—

2 “(1) OFFENSES OTHERWISE PUNISHABLE.—A  
3 penalty may not be imposed under subsection (a)  
4 with respect to an act if the act constitutes an of-  
5 fense punishable under section 1177.

6 “(2) NONCOMPLIANCE NOT DISCOVERED.—A  
7 penalty may not be imposed under subsection (a)  
8 with respect to a provision of this part if it is estab-  
9 lished to the satisfaction of the Secretary that the  
10 person liable for the penalty did not know, and by  
11 exercising reasonable diligence would not have  
12 known, that such person violated the provision.

13 “(3) FAILURES DUE TO REASONABLE CAUSE.—

14 “(A) IN GENERAL.—Except as provided in  
15 subparagraph (B), a penalty may not be im-  
16 posed under subsection (a) if—

17 “(i) the failure to comply was due to  
18 reasonable cause and not to willful neglect;  
19 and

20 “(ii) the failure to comply is corrected  
21 during the 30-day period beginning on the  
22 first date the person liable for the penalty  
23 knew, or by exercising reasonable diligence  
24 would have known, that the failure to com-  
25 ply occurred.

1 “(B) EXTENSION OF PERIOD.—

2 “(i) NO PENALTY.—The period re-  
3 ferred to in subparagraph (A)(ii) may be  
4 extended as determined appropriate by the  
5 Secretary based on the nature and extent  
6 of the failure to comply.

7 “(ii) ASSISTANCE.—If the Secretary  
8 determines that a person failed to comply  
9 because the person was unable to comply,  
10 the Secretary may provide technical assist-  
11 ance to the person during the period de-  
12 scribed in subparagraph (A)(ii). Such as-  
13 sistance shall be provided in any manner  
14 determined appropriate by the Secretary.

15 “(4) REDUCTION.—In the case of a failure to  
16 comply which is due to reasonable cause and not to  
17 willful neglect, any penalty under subsection (a) that  
18 is not entirely waived under paragraph (3) may be  
19 waived to the extent that the payment of such pen-  
20 alty would be excessive relative to the compliance  
21 failure involved.

22 “WRONGFUL DISCLOSURE OF INDIVIDUALLY  
23 IDENTIFIABLE HEALTH INFORMATION

24 “SEC. 1177. (a) OFFENSE.—A person who knowingly  
25 and in violation of this part—

1 “(1) uses or causes to be used a unique health  
2 identifier;

3 “(2) obtains individually identifiable health in-  
4 formation relating to an individual; or

5 “(3) discloses individually identifiable health in-  
6 formation to another person,

7 shall be punished as provided in subsection (b).

8 “(b) PENALTIES.—A person described in subsection  
9 (a) shall—

10 “(1) be fined not more than \$50,000, impris-  
11 oned not more than 1 year, or both;

12 “(2) if the offense is committed under false pre-  
13 tenses, be fined not more than \$100,000, imprisoned  
14 not more than 5 years, or both; and

15 “(3) if the offense is committed with intent to  
16 sell, transfer, or use individually identifiable health  
17 information for commercial advantage, personal  
18 gain, or malicious harm, fined not more than  
19 \$250,000, imprisoned not more than 10 years, or  
20 both.

21 “EFFECT ON STATE LAW

22 “SEC. 1178. (a) GENERAL EFFECT.—

23 “(1) GENERAL RULE.—Except as provided in  
24 paragraph (2), a provision or requirement under this  
25 part, or a standard or implementation specification  
26 adopted or established under sections 1172 through

1       1174, shall supersede any contrary provision of  
2       State law, including a provision of State law that re-  
3       quires medical or health plan records (including bill-  
4       ing information) to be maintained or transmitted in  
5       written rather than electronic form.

6               “(2) EXCEPTIONS.—A provision or requirement  
7       under this part, or a standard or implementation  
8       specification adopted or established under sections  
9       1172 through 1174, shall not supersede a contrary  
10      provision of State law, if the provision of State  
11      law—

12               “(A) imposes requirements, standards, or  
13      implementation specifications that are more  
14      stringent than the requirements, standards, or  
15      implementation specifications under this part  
16      with respect to the privacy of individually iden-  
17      tifiable health information; or

18               “(B) is a provision the Secretary deter-  
19      mines—

20               “(i) is necessary to prevent fraud and  
21      abuse, or for other purposes; or

22               “(ii) addresses controlled substances.

23               “(b) PUBLIC HEALTH REPORTING.—Nothing in this  
24      part shall be construed to invalidate or limit the authority,  
25      power, or procedures established under any law providing

1 for the reporting of disease or injury, child abuse, birth,  
2 or death, public health surveillance, or public health inves-  
3 tigation or intervention.”.

4 (b) CONFORMING AMENDMENTS.—

5 (1) REQUIREMENT FOR MEDICARE PROVID-  
6 ERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1))  
7 is amended—

8 (A) by striking “and” at the end of sub-  
9 paragraph (P);

10 (B) by striking the period at the end of  
11 subparagraph (Q) and inserting “; and”; and

12 (C) by inserting immediately after sub-  
13 paragraph (Q) the following new subparagraph:

14 “(R) to contract only with a clearinghouse (as  
15 defined in section 1171) that meets each standard  
16 and implementation specification adopted or estab-  
17 lished under part C of title XI on or after the date  
18 on which the clearinghouse is required to comply  
19 with the standard or specification.”.

20 (2) TITLE HEADING.—Title XI (42 U.S.C.  
21 1301 et seq.) is amended by striking the title head-  
22 ing and inserting the following:



1 “TITLE XI—GENERAL PROVISIONS, PEER RE-  
2 VIEW, AND ADMINISTRATIVE SIMPLIFICA-  
3 TION”.

4 **SEC. 253. CHANGES IN MEMBERSHIP AND DUTIES OF NA-**  
5 **TIONAL COMMITTEE ON VITAL AND HEALTH**  
6 **STATISTICS.**

7 Section 306(k) of the Public Health Service Act (42  
8 U.S.C. 242k(k)) is amended—

9 (1) in paragraph (1), by striking “16” and in-  
10 serting “18”;

11 (2) by amending paragraph (2) to read as fol-  
12 lows:

13 “(2) The members of the Committee shall be ap-  
14 pointed from among persons who have distinguished them-  
15 selves in the fields of health statistics, electronic inter-  
16 change of health care information, privacy and security  
17 of electronic information, population-based public health,  
18 purchasing or financing health care services, integrated  
19 computerized health information systems, health services  
20 research, consumer interests in health information, health  
21 data standards, epidemiology, and the provision of health  
22 services. Members of the Committee shall be appointed for  
23 terms of 4 years.”;

1           (3) by redesignating paragraphs (3) through  
2           (5) as paragraphs (4) through (6), respectively, and  
3           inserting after paragraph (2) the following:

4           “(3) Of the members of the Committee—

5                 “(A) 1 shall be appointed, not later than 60  
6                 days after the date of the enactment of the Health  
7                 Coverage Availability and Affordability Act of 1996,  
8                 by the Speaker of the House of Representatives  
9                 after consultation with the minority leader of the  
10                House of Representatives;

11               “(B) 1 shall be appointed, not later than 60  
12                days after the date of the enactment of the Health  
13                Coverage Availability and Affordability Act of 1996,  
14                by the President pro tempore of the Senate after  
15                consultation with the minority leader of the Senate;  
16                and

17               “(C) 16 shall be appointed by the Secretary.”;

18               (4) by amending paragraph (5) (as so redesign-  
19                ated) to read as follows:

20           “(5) The Committee—

21                 “(A) shall assist and advise the Secretary—

22                         “(i) to delineate statistical problems bear-  
23                         ing on health and health services which are of  
24                         national or international interest;

1           “(ii) to stimulate studies of such problems  
2           by other organizations and agencies whenever  
3           possible or to make investigations of such prob-  
4           lems through subcommittees;

5           “(iii) to determine, approve, and revise the  
6           terms, definitions, classifications, and guidelines  
7           for assessing health status and health services,  
8           their distribution and costs, for use (I) within  
9           the Department of Health and Human Services,  
10          (II) by all programs administered or funded by  
11          the Secretary, including the Federal-State-local  
12          cooperative health statistics system referred to  
13          in subsection (e), and (III) to the extent pos-  
14          sible as determined by the head of the agency  
15          involved, by the Department of Veterans Af-  
16          fairs, the Department of Defense, and other  
17          Federal agencies concerned with health and  
18          health services;

19          “(iv) with respect to the design of and ap-  
20          proval of health statistical and health informa-  
21          tion systems concerned with the collection, proc-  
22          essing, and tabulation of health statistics within  
23          the Department of Health and Human Services,  
24          with respect to the Cooperative Health Statis-  
25          tics System established under subsection (e),

1 and with respect to the standardized means for  
2 the collection of health information and statis-  
3 tics to be established by the Secretary under  
4 subsection (j)(1);

5 “(v) to review and comment on findings  
6 and proposals developed by other organizations  
7 and agencies and to make recommendations for  
8 their adoption or implementation by local,  
9 State, national, or international agencies;

10 “(vi) to cooperate with national committees  
11 of other countries and with the World Health  
12 Organization and other national agencies in the  
13 studies of problems of mutual interest;

14 “(vii) to issue an annual report on the  
15 state of the Nation’s health, its health services,  
16 their costs and distributions, and to make pro-  
17 posals for improvement of the Nation’s health  
18 statistics and health information systems; and

19 “(viii) in complying with the requirements  
20 imposed on the Secretary under part C of title  
21 XI of the Social Security Act;

22 “(B) shall study the issues related to the adop-  
23 tion of uniform data standards for patient medical  
24 record information and the electronic exchange of  
25 such information;

1           “(C) shall report to the Secretary not later than  
2       4 years after the date of the enactment of the  
3       Health Coverage Availability and Affordability Act  
4       of 1996 recommendations and legislative proposals  
5       for such standards and electronic exchange; and

6           “(D) shall be responsible generally for advising  
7       the Secretary and the Congress on the status of the  
8       implementation of part C of title XI of the Social  
9       Security Act.”; and

10           (5) by adding at the end the following:

11       “(7) Not later than 1 year after the date of the enact-  
12       ment of the Health Coverage Availability and Affordability  
13       Act of 1996, and annually thereafter, the Committee shall  
14       submit to the Congress, and make public, a report regard-  
15       ing—

16           “(A) the extent to which persons required to  
17       comply with part C of title XI of the Social Security  
18       Act are cooperating in implementing the standards  
19       adopted under such part;

20           “(B) the extent to which such entities are meet-  
21       ing the privacy and security standards adopted  
22       under such part and the types of penalties assessed  
23       for noncompliance with such standards;

1 “(C) whether the Federal and State Govern-  
 2 ments are receiving information of sufficient quality  
 3 to meet their responsibilities under such part;

4 “(D) any problems that exist with respect to  
 5 implementation of such part; and

6 “(E) the extent to which timetables under such  
 7 part are being met.”.

8 **Subtitle G—Duplication and Co-**  
 9 **ordination of Medicare-Related**  
 10 **Plans**

11 **SEC. 261. DUPLICATION AND COORDINATION OF MEDI-**  
 12 **CARE-RELATED PLANS.**

13 (a) TREATMENT OF CERTAIN HEALTH INSURANCE  
 14 POLICIES AS NONDUPLICATIVE.—Effective as if included  
 15 in the enactment of section 4354 of the Omnibus Budget  
 16 Reconciliation Act of 1990, section 1882(d)(3)(A) (42  
 17 U.S.C. 1395ss(d)(3)(A)) is amended—

18 (1) in clause (iii), by striking “clause (i)” and  
 19 inserting “clause (i)(II)”; and

20 (2) by adding at the end the following:

21 “(iv) For purposes of this subparagraph, a health in-  
 22 surance policy providing for benefits which are payable to  
 23 or on behalf of an individual without regard to other  
 24 health benefit coverage of such individual is not considered  
 25 to ‘duplicate’ any health benefits under this title, under

1 title XIX, or under a health insurance policy, and  
2 subclauses (I) and (III) of clause (i) does not apply to  
3 such a policy.

4 “(v)(I) For purposes of this subparagraph, a health  
5 insurance policy (or a rider to an insurance contract which  
6 is not a health insurance policy), providing benefits for  
7 long-term care, nursing home care, home health care, or  
8 community-based care and that coordinates against or ex-  
9 cludes items and services available or paid for under this  
10 title and (for policies sold or issued on or after 90 days  
11 after the date of enactment of this clause) that discloses  
12 such coordination or exclusion in the policy’s outline of  
13 coverage, is not considered to ‘duplicate’ health benefits  
14 under this title.

15 “(II) For purposes of this subparagraph, a health in-  
16 surance policy (which may be a contract with a health  
17 maintenance organization) that is a replacement product  
18 for another health insurance policy that is being termi-  
19 nated by the issuer, that is being provided to an individual  
20 entitled to benefits under part A on the basis of section  
21 226(b), and that coordinates against or excludes items and  
22 services available or paid for under this title is not consid-  
23 ered to ‘duplicate’ health benefits under this title.

24 “(III) For purposes of this clause, the terms ‘coordi-  
25 nates’ and ‘coordination’ mean, with respect to a policy

1 in relation to health benefits under this title, that the pol-  
2 icy under its terms is secondary to, or excludes from pay-  
3 ment, items and services to the extent available or paid  
4 for under this title.

5 “(vi) Notwithstanding any other provision of law, no  
6 criminal or civil penalty may be imposed at any time under  
7 this subparagraph and no legal action may be brought or  
8 continued at any time in any Federal or State court if  
9 the penalty or action is based on an act or omission that  
10 occurred after November 5, 1991, and before the date of  
11 the enactment of this clause, and relates to the sale, issu-  
12 ance, or renewal of any health insurance policy or rider  
13 during such period, if such policy or rider meets the non-  
14 duplication requirements of clause (iv) or (v).

15 “(vii) A State may not impose, in the case of the sale,  
16 issuance, or renewal of a health insurance policy (other  
17 than a medicare supplemental policy) or rider to an insur-  
18 ance contract which is not a health insurance policy, that  
19 meets the nonduplication requirements of this section pur-  
20 suant to clause (iv) or (v) to an individual entitled to bene-  
21 fits under part A or enrolled under part B, any require-  
22 ment relating to any duplication (or nonduplication) of  
23 health benefits under such policy or rider with health ben-  
24 efits to which the individual is otherwise entitled to under  
25 this title.”.



1 (b) CONFORMING AMENDMENTS.—Section  
 2 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

3 (1) in subparagraph (C)—

4 (A) by striking “with respect to (i)” and  
 5 inserting “with respect to”, and

6 (B) by striking “, (ii) the sale” and all  
 7 that follows up to the period at the end; and

8 (2) by striking subparagraph (D).

## 9 **Subtitle H—Medical Liability** 10 **Reform**

### 11 **PART 1—GENERAL PROVISIONS**

#### 12 **SEC. 271. FEDERAL REFORM OF HEALTH CARE LIABILITY** 13 **ACTIONS.**

14 (a) APPLICABILITY.—This subtitle shall apply with  
 15 respect to any health care liability action brought in any  
 16 State or Federal court, except that this subtitle shall not  
 17 apply to—

18 (1) an action for damages arising from a vac-  
 19 cine-related injury or death to the extent that title  
 20 XXI of the Public Health Service Act applies to the  
 21 action, or

22 (2) an action under the Employee Retirement  
 23 Income Security Act of 1974 (29 U.S.C. 1001 et  
 24 seq.).

1 (b) PREEMPTION.—This subtitle shall preempt any  
2 State law to the extent such law is inconsistent with the  
3 limitations contained in this subtitle. This subtitle shall  
4 not preempt any State law that provides for defenses or  
5 places limitations on a person’s liability in addition to  
6 those contained in this subtitle or otherwise imposes great-  
7 er restrictions than those provided in this subtitle.

8 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
9 OF LAW OR VENUE.—Nothing in subsection (b) shall be  
10 construed to—

11 (1) waive or affect any defense of sovereign im-  
12 munity asserted by any State under any provision of  
13 law;

14 (2) waive or affect any defense of sovereign im-  
15 munity asserted by the United States;

16 (3) affect the applicability of any provision of  
17 the Foreign Sovereign Immunities Act of 1976;

18 (4) preempt State choice-of-law rules with re-  
19 spect to claims brought by a foreign nation or a citi-  
20 zen of a foreign nation; or

21 (5) affect the right of any court to transfer  
22 venue or to apply the law of a foreign nation or to  
23 dismiss a claim of a foreign nation or of a citizen  
24 of a foreign nation on the ground of inconvenient  
25 forum.

1 (d) AMOUNT IN CONTROVERSY.—In an action to  
2 which this subtitle applies and which is brought under sec-  
3 tion 1332 of title 28, United States Code, the amount of  
4 noneconomic damages or punitive damages, and attorneys’  
5 fees or costs, shall not be included in determining whether  
6 the matter in controversy exceeds the sum or value of  
7 \$50,000.

8 (e) FEDERAL COURT JURISDICTION NOT ESTAB-  
9 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in  
10 this subtitle shall be construed to establish any jurisdiction  
11 in the district courts of the United States over health care  
12 liability actions on the basis of section 1331 or 1337 of  
13 title 28, United States Code.

14 **SEC. 272. DEFINITIONS.**

15 As used in this subtitle:

16 (1) ACTUAL DAMAGES.—The term “actual dam-  
17 ages” means damages awarded to pay for economic  
18 loss.

19 (2) ALTERNATIVE DISPUTE RESOLUTION SYS-  
20 TEM; ADR.—The term “alternative dispute resolution  
21 system” or “ADR” means a system established  
22 under Federal or State law that provides for the res-  
23 olution of health care liability claims in a manner  
24 other than through health care liability actions.

1           (3) CLAIMANT.—The term “claimant” means  
2           any person who brings a health care liability action  
3           and any person on whose behalf such an action is  
4           brought. If such action is brought through or on be-  
5           half of an estate, the term includes the claimant’s  
6           decedent. If such action is brought through or on be-  
7           half of a minor or incompetent, the term includes  
8           the claimant’s legal guardian.

9           (4) CLEAR AND CONVINCING EVIDENCE.—The  
10          term “clear and convincing evidence” is that meas-  
11          ure or degree of proof that will produce in the mind  
12          of the trier of fact a firm belief or conviction as to  
13          the truth of the allegations sought to be established.  
14          Such measure or degree of proof is more than that  
15          required under preponderance of the evidence but  
16          less than that required for proof beyond a reason-  
17          able doubt.

18          (5) COLLATERAL SOURCE PAYMENTS.—The  
19          term “collateral source payments” means any  
20          amount paid or reasonably likely to be paid in the  
21          future to or on behalf of a claimant, or any service,  
22          product, or other benefit provided or reasonably like-  
23          ly to be provided in the future to or on behalf of a  
24          claimant, as a result of an injury or wrongful death,  
25          pursuant to—

1 (A) any State or Federal health, sickness,  
2 income-disability, accident or workers' com-  
3 pensation Act;

4 (B) any health, sickness, income-disability,  
5 or accident insurance that provides health bene-  
6 fits or income-disability coverage;

7 (C) any contract or agreement of any  
8 group, organization, partnership, or corporation  
9 to provide, pay for, or reimburse the cost of  
10 medical, hospital, dental, or income disability  
11 benefits; and

12 (D) any other publicly or privately funded  
13 program.

14 (6) DRUG.—The term “drug” has the meaning  
15 given such term in section 201(g)(1) of the Federal  
16 Food, Drug, and Cosmetic Act (21 U.S.C.  
17 321(g)(1)).

18 (7) ECONOMIC LOSS.—The term “economic  
19 loss” means any pecuniary loss resulting from injury  
20 (including the loss of earnings or other benefits re-  
21 lated to employment, medical expense loss, replace-  
22 ment services loss, loss due to death, burial costs,  
23 and loss of business or employment opportunities),  
24 to the extent recovery for such loss is allowed under  
25 applicable State law.

1           (8) HARM.—The term “harm” means any le-  
2           gally cognizable wrong or injury for which punitive  
3           damages may be imposed.

4           (9) HEALTH BENEFIT PLAN.—The term  
5           “health benefit plan” means—

6                   (A) a hospital or medical expense incurred  
7                   policy or certificate,

8                   (B) a hospital or medical service plan con-  
9                   tract,

10                  (C) a health maintenance subscriber con-  
11                  tract,

12                  (D) a multiple employer welfare arrange-  
13                  ment or employee benefit plan (as defined  
14                  under the Employee Retirement Income Secu-  
15                  rity Act of 1974), or

16                  (E) a MedicarePlus product (offered under  
17                  part C of title XVIII of the Social Security  
18                  Act),

19           that provides benefits with respect to health care  
20           services.

21           (10) HEALTH CARE LIABILITY ACTION.—The  
22           term “health care liability action” means a civil ac-  
23           tion brought in a State or Federal court against a  
24           health care provider, an entity which is obligated to  
25           provide or pay for health benefits under any health

1 benefit plan (including any person or entity acting  
2 under a contract or arrangement to provide or ad-  
3 minister any health benefit), or the manufacturer,  
4 distributor, supplier, marketer, promoter, or seller of  
5 a medical product, in which the claimant alleges a  
6 claim (including third party claims, cross claims,  
7 counter claims, or distribution claims) based upon  
8 the provision of (or the failure to provide or pay for)  
9 health care services or the use of a medical product,  
10 regardless of the theory of liability on which the  
11 claim is based or the number of plaintiffs, defend-  
12 ants, or causes of action.

13 (11) HEALTH CARE LIABILITY CLAIM.—The  
14 term “health care liability claim” means a claim in  
15 which the claimant alleges that injury was caused by  
16 the provision of (or the failure to provide) health  
17 care services.

18 (12) HEALTH CARE PROVIDER.—The term  
19 “health care provider” means any person that is en-  
20 gaged in the delivery of health care services in a  
21 State and that is required by the laws or regulations  
22 of the State to be licensed or certified by the State  
23 to engage in the delivery of such services in the  
24 State.

1           (13) HEALTH CARE SERVICE.—The term  
2           “health care service” means any service for which  
3           payment may be made under a health benefit plan  
4           including services related to the delivery or adminis-  
5           tration of such service.

6           (14) MEDICAL DEVICE.—The term “medical de-  
7           vice” has the meaning given such term in section  
8           201(h) of the Federal Food, Drug, and Cosmetic  
9           Act (21 U.S.C. 321(h)).

10          (15) NONECONOMIC DAMAGES.—The term  
11          “noneconomic damages” means damages paid to an  
12          individual for pain and suffering, inconvenience,  
13          emotional distress, mental anguish, loss of consor-  
14          tium, injury to reputation, humiliation, and other  
15          nonpecuniary losses.

16          (16) PERSON.—The term “person” means any  
17          individual, corporation, company, association, firm,  
18          partnership, society, joint stock company, or any  
19          other entity, including any governmental entity.

20          (17) PRODUCT SELLER.—The term “product  
21          seller” means a person who, in the course of a busi-  
22          ness conducted for that purpose, sells, distributes,  
23          rents, leases, prepares, blends, packages, labels a  
24          product, is otherwise involved in placing a product in  
25          the stream of commerce, or installs, repairs, or



1 maintains the harm-causing aspect of a product.

2 The term does not include—

3 (A) a seller or lessor of real property;

4 (B) a provider of professional services in  
5 any case in which the sale or use of a product  
6 is incidental to the transaction and the essence  
7 of the transaction is the furnishing of judg-  
8 ment, skill, or services; or

9 (C) any person who—

10 (i) acts in only a financial capacity  
11 with respect to the sale of a product; or

12 (ii) leases a product under a lease ar-  
13 rangement in which the selection, posses-  
14 sion, maintenance, and operation of the  
15 product are controlled by a person other  
16 than the lessor.

17 (18) PUNITIVE DAMAGES.—The term “punitive  
18 damages” means damages awarded against any per-  
19 son not to compensate for actual injury suffered, but  
20 to punish or deter such person or others from en-  
21 gaging in similar behavior in the future.

22 (19) STATE.—The term “State” means each of  
23 the several States, the District of Columbia, Puerto  
24 Rico, the Virgin Islands, Guam, American Samoa,

1 the Northern Mariana Islands, and any other terri-  
2 tory or possession of the United States.

3 **SEC. 273. EFFECTIVE DATE.**

4 This subtitle will apply to any health care liability ac-  
5 tion brought in a Federal or State court and to any health  
6 care liability claim subject to an alternative dispute resolu-  
7 tion system, that is initiated on or after the date of enact-  
8 ment of this subtitle, except that any health care liability  
9 claim or action arising from an injury occurring prior to  
10 the date of enactment of this subtitle shall be governed  
11 by the applicable statute of limitations provisions in effect  
12 at the time the injury occurred.

13 **PART 2—UNIFORM STANDARDS FOR HEALTH**  
14 **CARE LIABILITY ACTIONS**

15 **SEC. 281. STATUTE OF LIMITATIONS.**

16 A health care liability action may not be brought  
17 after the expiration of the 2-year period that begins on  
18 the date on which the alleged injury that is the subject  
19 of the action was discovered or should reasonably have  
20 been discovered, but in no case after the expiration of the  
21 5-year period that begins on the date the alleged injury  
22 occurred.

23 **SEC. 282. CALCULATION AND PAYMENT OF DAMAGES.**

24 (a) TREATMENT OF NONECONOMIC DAMAGES.—

1           (1) LIMITATION ON NONECONOMIC DAMAGES.—

2           The total amount of noneconomic damages that may  
3           be awarded to a claimant for losses resulting from  
4           the injury which is the subject of a health care liabil-  
5           ity action may not exceed \$250,000, regardless of  
6           the number of parties against whom the action is  
7           brought or the number of actions brought with re-  
8           spect to the injury.

9           (2) JOINT AND SEVERAL LIABILITY.—In any  
10          health care liability action brought in State or Fed-  
11          eral court, a defendant shall be liable only for the  
12          amount of noneconomic damages attributable to  
13          such defendant in direct proportion to such defend-  
14          ant's share of fault or responsibility for the claim-  
15          ant's actual damages, as determined by the trier of  
16          fact. In all such cases, the liability of a defendant  
17          for noneconomic damages shall be several and not  
18          joint.

19          (b) TREATMENT OF PUNITIVE DAMAGES.—

20               (1) GENERAL RULE.—Punitive damages may,  
21               to the extent permitted by applicable State law, be  
22               awarded in any health care liability action for harm  
23               in any Federal or State court against a defendant if  
24               the claimant establishes by clear and convincing evi-

1       dence that the harm suffered was the result of con-  
2       duct—

3               (A) specifically intended to cause harm, or

4               (B) conduct manifesting a conscious, fla-  
5       grant indifference to the rights or safety of oth-  
6       ers.

7       (2) PROPORTIONAL AWARDS.—The amount of  
8       punitive damages that may be awarded in any health  
9       care liability action subject to this subtitle shall not  
10      exceed 3 times the amount of damages awarded to  
11      the claimant for economic loss, or \$250,000, which-  
12      ever is greater. This paragraph shall be applied by  
13      the court and shall not be disclosed to the jury.

14      (3) APPLICABILITY.—This subsection shall  
15      apply to any health care liability action brought in  
16      any Federal or State court on any theory where pu-  
17      nitive damages are sought. This subsection does not  
18      create a cause of action for punitive damages. This  
19      subsection does not preempt or supersede any State  
20      or Federal law to the extent that such law would  
21      further limit the award of punitive damages.

22      (4) BIFURCATION.—At the request of any  
23      party, the trier of fact shall consider in a separate  
24      proceeding whether punitive damages are to be  
25      awarded and the amount of such award. If a sepa-

1 rate proceeding is requested, evidence relevant only  
2 to the claim of punitive damages, as determined by  
3 applicable State law, shall be inadmissible in any  
4 proceeding to determine whether actual damages are  
5 to be awarded.

6 (5) DRUGS AND DEVICES.—

7 (A) IN GENERAL.—(i) Punitive damages  
8 shall not be awarded against a manufacturer or  
9 product seller of a drug or medical device which  
10 caused the claimant's harm where—

11 (I) such drug or device was subject to  
12 premarket approval by the Food and Drug  
13 Administration with respect to the safety  
14 of the formulation or performance of the  
15 aspect of such drug or device which caused  
16 the claimant's harm, or the adequacy of  
17 the packaging or labeling of such drug or  
18 device which caused the harm, and such  
19 drug, device, packaging, or labeling was  
20 approved by the Food and Drug Adminis-  
21 tration; or

22 (II) the drug is generally recognized  
23 as safe and effective pursuant to conditions  
24 established by the Food and Drug Admin-

1           istration and applicable regulations, includ-  
2           ing packaging and labeling regulations.

3           (ii) Clause (i) shall not apply in any case  
4           in which the defendant, before or after pre-  
5           market approval of a drug or device—

6                   (I) intentionally and wrongfully with-  
7                   held from or misrepresented to the Food  
8                   and Drug Administration information con-  
9                   cerning such drug or device required to be  
10                  submitted under the Federal Food, Drug,  
11                  and Cosmetic Act (21 U.S.C. 301 et seq.)  
12                  or section 351 of the Public Health Service  
13                  Act (42 U.S.C. 262) that is material and  
14                  relevant to the harm suffered by the claim-  
15                  ant, or

16                  (II) made an illegal payment to an of-  
17                  ficial or employee of the Food and Drug  
18                  Administration for the purpose of securing  
19                  or maintaining approval of such drug or  
20                  device.

21           (B) PACKAGING.—In a health care liability  
22           action for harm which is alleged to relate to the  
23           adequacy of the packaging or labeling of a drug  
24           which is required to have tamper-resistant  
25           packaging under regulations of the Secretary of

1           Health and Human Services (including labeling  
2           regulations related to such packaging), the  
3           manufacturer or product seller of the drug shall  
4           not be held liable for punitive damages unless  
5           such packaging or labeling is found by the court  
6           by clear and convincing evidence to be substan-  
7           tially out of compliance with such regulations.

8           (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

9           (1) GENERAL RULE.—In any health care liabil-  
10          ity action in which the damages awarded for future  
11          economic and noneconomic loss exceeds \$50,000, a  
12          person shall not be required to pay such damages in  
13          a single, lump-sum payment, but shall be permitted  
14          to make such payments periodically based on when  
15          the damages are found likely to occur, as such pay-  
16          ments are determined by the court.

17          (2) FINALITY OF JUDGMENT.—The judgment  
18          of the court awarding periodic payments under this  
19          subsection may not, in the absence of fraud, be re-  
20          opened at any time to contest, amend, or modify the  
21          schedule or amount of the payments.

22          (3) LUMP-SUM SETTLEMENTS.—This sub-  
23          section shall not be construed to preclude a settle-  
24          ment providing for a single, lump-sum payment.

1 (d) TREATMENT OF COLLATERAL SOURCE PAY-  
2 MENTS.—

3 (1) INTRODUCTION INTO EVIDENCE.—In any  
4 health care liability action, any defendant may intro-  
5 duce evidence of collateral source payments. If any  
6 defendant elects to introduce such evidence, the  
7 claimant may introduce evidence of any amount paid  
8 or contributed or reasonably likely to be paid or con-  
9 tributed in the future by or on behalf of the claim-  
10 ant to secure the right to such collateral source pay-  
11 ments.

12 (2) NO SUBROGATION.—No provider of collat-  
13 eral source payments shall recover any amount  
14 against the claimant or receive any lien or credit  
15 against the claimant's recovery or be equitably or le-  
16 gally subrogated the right of the claimant in a  
17 health care liability action.

18 (3) APPLICATION TO SETTLEMENTS.—This sub-  
19 section shall apply to an action that is settled as well  
20 as an action that is resolved by a fact finder.

21 **SEC. 283. ALTERNATIVE DISPUTE RESOLUTION.**

22 Any ADR used to resolve a health care liability action  
23 or claim shall contain provisions relating to statute of limi-  
24 tations, non-economic damages, joint and several liability,  
25 punitive damages, collateral source rule, and periodic pay-



1 ments which are identical to the provisions relating to  
 2 such matters in this subtitle.

### 3 **TITLE III—TAX-RELATED** 4 **HEALTH PROVISIONS**

#### 5 **SEC. 300. AMENDMENT OF 1986 CODE.**

6 Except as otherwise expressly provided, whenever in  
 7 this title an amendment or repeal is expressed in terms  
 8 of an amendment to, or repeal of, a section or other provi-  
 9 sion, the reference shall be considered to be made to a  
 10 section or other provision of the Internal Revenue Code  
 11 of 1986.

### 12 **Subtitle A—Medical Savings** 13 **Accounts**

#### 14 **SEC. 301. MEDICAL SAVINGS ACCOUNTS.**

15 (a) IN GENERAL.—Part VII of subchapter B of chap-  
 16 ter 1 (relating to additional itemized deductions for indi-  
 17 viduals) is amended by redesignating section 220 as sec-  
 18 tion 221 and by inserting after section 219 the following  
 19 new section:

#### 20 **“SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

21 “(a) DEDUCTION ALLOWED.—In the case of an indi-  
 22 vidual who is an eligible individual for any month during  
 23 the taxable year, there shall be allowed as a deduction for  
 24 the taxable year an amount equal to the aggregate amount

1 paid in cash during such taxable year by such individual  
2 to a medical savings account of such individual.

3 “(b) LIMITATIONS.—

4 “(1) IN GENERAL.—Except as otherwise pro-  
5 vided in this subsection, the amount allowable as a  
6 deduction under subsection (a) to an individual for  
7 the taxable year shall not exceed—

8 “(A) except as provided in subparagraph  
9 (B), the lesser of—

10 “(i) \$2,000, or

11 “(ii) the annual deductible limit for  
12 any individual covered under the high de-  
13 ductible health plan, or

14 “(B) in the case of a high deductible  
15 health plan covering the taxpayer and any other  
16 eligible individual who is the spouse or any de-  
17 pendent (as defined in section 152) of the tax-  
18 payer, the lesser of—

19 “(i) \$4,000, or

20 “(ii) the annual limit under the plan  
21 on the aggregate amount of deductibles re-  
22 quired to be paid by all individuals.

23 The preceding sentence shall not apply if the spouse  
24 of such individual is covered under any other high  
25 deductible health plan.

1           “(2) SPECIAL RULE FOR MARRIED INDIVID-  
2           UALS.—

3                   “(A) IN GENERAL.—This subsection shall  
4           be applied separately for each married individ-  
5           ual.

6                   “(B) SPECIAL RULE.—If individuals who  
7           are married to each other are covered under the  
8           same high deductible health plan, then the  
9           amounts applicable under paragraph (1)(B)  
10          shall be divided equally between them unless  
11          they agree on a different division.

12           “(3) COORDINATION WITH EXCLUSION FOR EM-  
13          PLOYER CONTRIBUTIONS.—No deduction shall be al-  
14          lowed under this section for any amount paid for  
15          any taxable year to a medical savings account of an  
16          individual if—

17                   “(A) any amount is paid to any medical  
18          savings account of such individual which is ex-  
19          cludable from gross income under section  
20          106(b) for such year, or

21                   “(B) in a case described in paragraph  
22          (2)(B), any amount is paid to any medical sav-  
23          ings account of either spouse which is so ex-  
24          cludable for such year.

25           “(4) PRORATION OF LIMITATION.—

1           “(A) IN GENERAL.—The limitation under  
2           paragraph (1) shall be the sum of the monthly  
3           limitations for months during the taxable year  
4           that the individual is an eligible individual if—

5                   “(i) such individual is not an eligible  
6                   individual for all months of the taxable  
7                   year,

8                   “(ii) the deductible under the high de-  
9                   ductible health plan covering such individ-  
10                  ual is not the same throughout such tax-  
11                  able year, or

12                  “(iii) such limitation is determined  
13                  under paragraph (1)(B) for some but not  
14                  all months during such taxable year.

15           “(B) MONTHLY LIMITATION.—The month-  
16           ly limitation for any month shall be an amount  
17           equal to  $\frac{1}{12}$  of the limitation which would (but  
18           for this paragraph and paragraph (3)) be deter-  
19           mined under paragraph (1) if the facts and cir-  
20           cumstances as of the first day of such month  
21           that such individual is covered under a high de-  
22           ductible health plan were true for the entire  
23           taxable year.

24           “(5) DENIAL OF DEDUCTION TO DEPEND-  
25           ENTS.—No deduction shall be allowed under this

1 section to any individual with respect to whom a de-  
2 duction under section 151 is allowable to another  
3 taxpayer for a taxable year beginning in the cal-  
4 endar year in which such individual's taxable year  
5 begins.

6 “(c) DEFINITIONS.—For purposes of this section—

7 “(1) ELIGIBLE INDIVIDUAL.—

8 “(A) IN GENERAL.—The term ‘eligible in-  
9 dividual’ means, with respect to any month, any  
10 individual—

11 “(i) who is covered under a high de-  
12 ductible health plan as of the 1st day of  
13 such month, and

14 “(ii) who is not, while covered under  
15 a high deductible health plan, covered  
16 under any health plan—

17 “(I) which is not a high deduct-  
18 ible health plan, and

19 “(II) which provides coverage for  
20 any benefit which is covered under the  
21 high deductible health plan.

22 “(B) CERTAIN COVERAGE DIS-  
23 REGARDED.—Subparagraph (A)(ii) shall be ap-  
24 plied without regard to—

1 “(i) coverage for any benefit provided  
2 by permitted insurance, and

3 “(ii) coverage (whether through insur-  
4 ance or otherwise) for accidents, disability,  
5 dental care, vision care, or long-term care.

6 “(2) HIGH DEDUCTIBLE HEALTH PLAN.—The  
7 term ‘high deductible health plan’ means a health  
8 plan which—

9 “(A) has an annual deductible limit for  
10 each individual covered by the plan which is not  
11 less than \$1,500, and

12 “(B) has an annual limit on the aggregate  
13 amount of deductibles required to be paid with  
14 respect to all individuals covered by the plan  
15 which is not less than \$3,000.

16 Such term does not include a health plan if substan-  
17 tially all of its coverage is coverage described in  
18 paragraph (1)(B). A plan shall not fail to be treated  
19 as a high deductible health plan by reason of failing  
20 to have a deductible for preventive care if the ab-  
21 sence of a deductible for such care is required by  
22 State law.

23 “(3) PERMITTED INSURANCE.—The term ‘per-  
24 mitted insurance’ means—

25 “(A) Medicare supplemental insurance,

1           “(B) insurance if substantially all of the  
2           coverage provided under such insurance relates  
3           to—

4                   “(i) liabilities incurred under workers’  
5           compensation laws,

6                   “(ii) tort liabilities,

7                   “(iii) liabilities relating to ownership  
8           or use of property, or

9                   “(iv) such other similar liabilities as  
10          the Secretary may specify by regulations,

11          “(C) insurance for a specified disease or  
12          illness, and

13          “(D) insurance paying a fixed amount per  
14          day (or other period) of hospitalization.

15          “(d) MEDICAL SAVINGS ACCOUNT.—For purposes of  
16          this section—

17               “(1) MEDICAL SAVINGS ACCOUNT.—The term  
18          ‘medical savings account’ means a trust created or  
19          organized in the United States exclusively for the  
20          purpose of paying the qualified medical expenses of  
21          the account holder, but only if the written governing  
22          instrument creating the trust meets the following re-  
23          quirements:

1           “(A) Except in the case of a rollover con-  
2           tribution described in subsection (f)(5), no con-  
3           tribution will be accepted—

4                   “(i) unless it is in cash, or

5                   “(ii) to the extent such contribution,  
6           when added to previous contributions to  
7           the trust for the calendar year, exceeds  
8           \$4,000.

9           “(B) The trustee is a bank (as defined in  
10          section 408(n)), an insurance company (as de-  
11          fined in section 816), or another person who  
12          demonstrates to the satisfaction of the Sec-  
13          retary that the manner in which such person  
14          will administer the trust will be consistent with  
15          the requirements of this section.

16          “(C) No part of the trust assets will be in-  
17          vested in life insurance contracts.

18          “(D) The assets of the trust will not be  
19          commingled with other property except in a  
20          common trust fund or common investment  
21          fund.

22          “(E) The interest of an individual in the  
23          balance in his account is nonforfeitable.

24          “(2) QUALIFIED MEDICAL EXPENSES.—



1           “(A) IN GENERAL.—The term ‘qualified  
2           medical expenses’ means, with respect to an ac-  
3           count holder, amounts paid by such holder for  
4           medical care (as defined in section 213(d)) for  
5           such individual, the spouse of such individual,  
6           and any dependent (as defined in section 152)  
7           of such individual, but only to the extent such  
8           amounts are not compensated for by insurance  
9           or otherwise.

10           “(B) HEALTH INSURANCE MAY NOT BE  
11           PURCHASED FROM ACCOUNT.—

12           “(i) IN GENERAL.—Subparagraph (A)  
13           shall not apply to any payment for insur-  
14           ance.

15           “(ii) EXCEPTIONS.—Clause (i) shall  
16           not apply to any expense for coverage  
17           under—

18           “(I) a health plan during any pe-  
19           riod of continuation coverage required  
20           under any Federal law,

21           “(II) a qualified long-term care  
22           insurance contract (as defined in sec-  
23           tion 7702B(b)), or

24           “(III) a health plan during a pe-  
25           riod in which the individual is receiv-

1                   ing     unemployment     compensation  
2                   under any Federal or State law.

3               “(3) ACCOUNT HOLDER.—The term ‘account  
4     holder’ means the individual on whose behalf the  
5     medical savings account was established.

6               “(4) CERTAIN RULES TO APPLY.—Rules similar  
7     to the following rules shall apply for purposes of this  
8     section:

9                   “(A) Section 219(d)(2) (relating to no de-  
10     duction for rollovers).

11                  “(B) Section 219(f)(3) (relating to time  
12     when contributions deemed made).

13                  “(C) Except as provided in section 106(b),  
14     section 219(f)(5) (relating to employer pay-  
15     ments).

16                  “(D) Section 408(g) (relating to commu-  
17     nity property laws).

18                  “(E) Section 408(h) (relating to custodial  
19     accounts).

20     “(e) TAX TREATMENT OF ACCOUNTS.—

21               “(1) IN GENERAL.—A medical savings account  
22     is exempt from taxation under this subtitle unless  
23     such account has ceased to be a medical savings ac-  
24     count by reason of paragraph (2) or (3). Notwith-  
25     standing the preceding sentence, any such account is

1 subject to the taxes imposed by section 511 (relating  
2 to imposition of tax on unrelated business income of  
3 charitable, etc. organizations).

4 “(2) ACCOUNT TERMINATIONS.—Rules similar  
5 to the rules of paragraphs (2) and (4) of section  
6 408(e) shall apply to medical savings accounts, and  
7 any amount treated as distributed under such rules  
8 shall be treated as not used to pay qualified medical  
9 expenses.

10 “(f) TAX TREATMENT OF DISTRIBUTIONS.—

11 “(1) AMOUNTS USED FOR QUALIFIED MEDICAL  
12 EXPENSES.—

13 “(A) IN GENERAL.—Any amount paid or  
14 distributed out of a medical savings account  
15 which is used exclusively to pay qualified medi-  
16 cal expenses of any account holder (or any  
17 spouse or dependent of the holder) shall not be  
18 includible in gross income.

19 “(B) TREATMENT AFTER DEATH OF AC-  
20 COUNT HOLDER.—

21 “(i) TREATMENT IF HOLDER IS  
22 SPOUSE.—If, after the death of the ac-  
23 count holder, the account holder’s interest  
24 is payable to (or for the benefit of) the  
25 holder’s spouse, the medical savings ac-

1 count shall be treated as if the spouse were  
2 the account holder.

3 “(ii) TREATMENT IF DESIGNATED  
4 HOLDER IS NOT SPOUSE.—In the case of  
5 an account holder’s interest in a medical  
6 savings account which is payable to (or for  
7 the benefit of) any person other than such  
8 holder’s spouse upon the death of such  
9 holder—

10 “(I) such account shall cease to  
11 be a medical savings account as of the  
12 date of death, and

13 “(II) an amount equal to the fair  
14 market value of the assets in such ac-  
15 count on such date shall be includible  
16 if such person is not the estate of  
17 such holder, in such person’s gross in-  
18 come for the taxable year which in-  
19 cludes such date, or if such person is  
20 the estate of such holder, in such  
21 holder’s gross income for the last tax-  
22 able year of such holder.

23 “(2) INCLUSION OF AMOUNTS NOT USED FOR  
24 QUALIFIED MEDICAL EXPENSES.—

1           “(A) IN GENERAL.—Any amount paid or  
2           distributed out of a medical savings account  
3           which is not used exclusively to pay the quali-  
4           fied medical expenses of the account holder or  
5           of the spouse or dependents of such holder shall  
6           be included in the gross income of such holder.

7           “(B) SPECIAL RULES.—For purposes of  
8           subparagraph (A)—

9                   “(i) all medical savings accounts of  
10                  the account holder shall be treated as 1 ac-  
11                  count,

12                   “(ii) all payments and distributions  
13                  during any taxable year shall be treated as  
14                  1 distribution, and

15                   “(iii) any distribution of property  
16                  shall be taken into account at its fair mar-  
17                  ket value on the date of the distribution.

18           “(3) EXCESS CONTRIBUTIONS RETURNED BE-  
19           FORE DUE DATE OF RETURN.—If the aggregate con-  
20           tributions (other than rollover contributions) for a  
21           taxable year to the medical savings accounts of an  
22           individual exceed the amount allowable as a deduc-  
23           tion under this section for such contributions, para-  
24           graph (2) shall not apply to distributions from such

1 accounts (in an amount not greater than such ex-  
2 cess) if—

3 “(A) such distribution is received by the  
4 individual on or before the last day prescribed  
5 by law (including extensions of time) for filing  
6 such individual’s return for such taxable year,  
7 and

8 “(B) such distribution is accompanied by  
9 the amount of net income attributable to such  
10 excess contribution.

11 Any net income described in subparagraph (B) shall  
12 be included in the gross income of the individual for  
13 the taxable year in which it is received.

14 “(4) PENALTY FOR DISTRIBUTIONS NOT USED  
15 FOR QUALIFIED MEDICAL EXPENSES.—

16 “(A) IN GENERAL.—The tax imposed by  
17 this chapter on the account holder for any tax-  
18 able year in which there is a payment or dis-  
19 tribution from a medical savings account of  
20 such holder which is includible in gross income  
21 under paragraph (2) shall be increased by 10  
22 percent of the amount which is so includible.

23 “(B) EXCEPTION FOR DISABILITY OR  
24 DEATH.—Subparagraph (A) shall not apply if  
25 the payment or distribution is made after the

1 account holder becomes disabled within the  
2 meaning of section 72(m)(7) or dies.

3 “(C) EXCEPTION FOR DISTRIBUTIONS  
4 AFTER AGE 59½.—Subparagraph (A) shall not  
5 apply to any payment or distribution after the  
6 date on which the account holder attains age  
7 59½.

8 “(5) ROLLOVER CONTRIBUTION.—An amount is  
9 described in this paragraph as a rollover contribu-  
10 tion if it meets the requirements of subparagraphs  
11 (A) and (B).

12 “(A) IN GENERAL.—Paragraph (2) shall  
13 not apply to any amount paid or distributed  
14 from a medical savings account to the account  
15 holder to the extent the amount received is paid  
16 into a medical savings account for the benefit  
17 of such holder not later than the 60th day after  
18 the day on which the holder receives the pay-  
19 ment or distribution.

20 “(B) LIMITATION.—This paragraph shall  
21 not apply to any amount described in subpara-  
22 graph (A) received by an individual from a  
23 medical savings account if, at any time during  
24 the 1-year period ending on the day of such re-  
25 ceipt, such individual received any other amount

1 described in subparagraph (A) from a medical  
2 savings account which was not includible in the  
3 individual's gross income because of the appli-  
4 cation of this paragraph.

5 “(6) COORDINATION WITH MEDICAL EXPENSE  
6 DEDUCTION.—For purposes of determining the  
7 amount of the deduction under section 213, any pay-  
8 ment or distribution out of a medical savings ac-  
9 count for qualified medical expenses shall not be  
10 treated as an expense paid for medical care.

11 “(7) TRANSFER OF ACCOUNT INCIDENT TO DI-  
12 VORCE.—The transfer of an individual's interest in  
13 a medical savings account to an individual's spouse  
14 or former spouse under a divorce or separation in-  
15 strument described in subparagraph (A) of section  
16 71(b)(2) shall not be considered a taxable transfer  
17 made by such individual notwithstanding any other  
18 provision of this subtitle, and such interest shall,  
19 after such transfer, be treated as a medical savings  
20 account with respect to which the spouse is the ac-  
21 count holder.

22 “(g) COST-OF-LIVING ADJUSTMENT.—

23 “(1) IN GENERAL.—In the case of any taxable  
24 year beginning in a calendar year after 1997, each  
25 dollar amount in subsection (b)(1), (c)(2), or



1 (d)(1)(A) shall be increased by an amount equal  
2 to—

3 “(A) such dollar amount, multiplied by

4 “(B) the medical care cost adjustment for  
5 such calendar year.

6 If any increase under the preceding sentence is not  
7 a multiple of \$50, such increase shall be rounded to  
8 the nearest multiple of \$50.

9 “(2) MEDICAL CARE COST ADJUSTMENT.—For  
10 purposes of paragraph (1), the medical care cost ad-  
11 justment for any calendar year is the percentage (if  
12 any) by which—

13 “(A) the medical care component of the  
14 Consumer Price Index (as defined in section  
15 1(f)(5)) for August of the preceding calendar  
16 year, exceeds

17 “(B) such component for August of 1996.

18 “(h) REPORTS.—The Secretary may require the  
19 trustee of a medical savings account to make such reports  
20 regarding such account to the Secretary and to the ac-  
21 count holder with respect to contributions, distributions,  
22 and such other matters as the Secretary determines appro-  
23 priate. The reports required by this subsection shall be  
24 filed at such time and in such manner and furnished to

1 such individuals at such time and in such manner as may  
2 be required by those regulations.”

3 (b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL  
4 ITEMIZES OTHER DEDUCTIONS.—Subsection (a)  
5 of section 62 is amended by inserting after paragraph (15)  
6 the following new paragraph:

7 “(16) MEDICAL SAVINGS ACCOUNTS.—The de-  
8 duction allowed by section 220.”

9 (c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO  
10 MEDICAL SAVINGS ACCOUNTS.—

11 (1) EXCLUSION FROM INCOME TAX.—The text  
12 of section 106 (relating to contributions by employer  
13 to accident and health plans) is amended to read as  
14 follows:

15 “(a) GENERAL RULE.—Except as otherwise provided  
16 in this section, gross income of an employee does not in-  
17 clude employer-provided coverage under an accident or  
18 health plan.

19 “(b) CONTRIBUTIONS TO MEDICAL SAVINGS AC-  
20 COUNTS.—

21 “(1) IN GENERAL.—In the case of an employee  
22 who is an eligible individual, gross income does not  
23 include amounts contributed by such employee’s em-  
24 ployer to any medical savings account of such em-  
25 ployee.

1           “(2) COORDINATION WITH DEDUCTION LIMITA-  
2           TION.—The amount excluded from the gross income  
3           of an employee under this subsection for any taxable  
4           year shall not exceed the limitation under section  
5           220(b)(1) (determined without regard to this sub-  
6           section) which is applicable to such employee for  
7           such taxable year.

8           “(3) NO CONSTRUCTIVE RECEIPT.—No amount  
9           shall be included in the gross income of any em-  
10          ployee solely because the employee may choose be-  
11          tween the contributions referred to in paragraph (1)  
12          and employer contributions to another health plan of  
13          the employer.

14          “(4) SPECIAL RULE FOR DEDUCTION OF EM-  
15          PLOYER CONTRIBUTIONS.—Any employer contribu-  
16          tion to a medical savings account, if otherwise allow-  
17          able as a deduction under this chapter, shall be al-  
18          lowed only for the taxable year in which paid.

19          “(5) DEFINITIONS.—For purposes of this sub-  
20          section, the terms ‘eligible individual’ and ‘medical  
21          savings account’ have the respective meanings given  
22          to such terms by section 220.”

23                 (2) EXCLUSION FROM EMPLOYMENT TAXES.—

24                         (A) SOCIAL SECURITY TAXES.—

1                   (i) Subsection (a) of section 3121 is  
2                   amended by striking “or” at the end of  
3                   paragraph (20), by striking the period at  
4                   the end of paragraph (21) and inserting “;  
5                   or”, and by inserting after paragraph (21)  
6                   the following new paragraph:

7                   “(22) any payment made to or for the benefit  
8                   of an employee if at the time of such payment it is  
9                   reasonable to believe that the employee will be able  
10                  to exclude such payment from income under section  
11                  106(b).”

12                  (ii) Subsection (a) of section 209 of  
13                  the Social Security Act is amended by  
14                  striking “or” at the end of paragraph (17),  
15                  by striking the period at the end of para-  
16                  graph (18) and inserting “; or”, and by in-  
17                  serting after paragraph (18) the following  
18                  new paragraph:

19                  “(19) any payment made to or for the benefit  
20                  of an employee if at the time of such payment it is  
21                  reasonable to believe that the employee will be able  
22                  to exclude such payment from income under section  
23                  106(b) of the Internal Revenue Code of 1986.”

1 (B) RAILROAD RETIREMENT TAX.—Sub-  
2 section (e) of section 3231 is amended by add-  
3 ing at the end the following new paragraph:

4 “(10) MEDICAL SAVINGS ACCOUNT CONTRIBU-  
5 TIONS.—The term ‘compensation’ shall not include  
6 any payment made to or for the benefit of an em-  
7 ployee if at the time of such payment it is reason-  
8 able to believe that the employee will be able to ex-  
9 clude such payment from income under section  
10 106(b).”

11 (C) UNEMPLOYMENT TAX.—Subsection (b)  
12 of section 3306 is amended by striking “or” at  
13 the end of paragraph (15), by striking the pe-  
14 riod at the end of paragraph (16) and inserting  
15 “; or”, and by inserting after paragraph (16)  
16 the following new paragraph:

17 “(17) any payment made to or for the benefit  
18 of an employee if at the time of such payment it is  
19 reasonable to believe that the employee will be able  
20 to exclude such payment from income under section  
21 106(b).”

22 (D) WITHHOLDING TAX.—Subsection (a)  
23 of section 3401 is amended by striking “or” at  
24 the end of paragraph (19), by striking the pe-  
25 riod at the end of paragraph (20) and inserting

1           “; or”, and by inserting after paragraph (20)  
2           the following new paragraph:

3           “(21) any payment made to or for the benefit  
4           of an employee if at the time of such payment it is  
5           reasonable to believe that the employee will be able  
6           to exclude such payment from income under section  
7           106(b).”

8           (d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS  
9           NOT AVAILABLE UNDER CAFETERIA PLANS.—Subsection  
10          (f) of section 125 of such Code is amended by inserting  
11          “106(b),” before “117”.

12          (e) EXCLUSION OF MEDICAL SAVINGS ACCOUNTS  
13          FROM ESTATE TAX.—Part IV of subchapter A of chapter  
14          11 is amended by adding at the end the following new  
15          section:

16          **“SEC. 2057. MEDICAL SAVINGS ACCOUNTS.**

17                “For purposes of the tax imposed by section 2001,  
18          the value of the taxable estate shall be determined by de-  
19          ducting from the value of the gross estate an amount  
20          equal to the value of any medical savings account (as de-  
21          fined in section 220(d)) included in the gross estate.”

22          (f) TAX ON EXCESS CONTRIBUTIONS.—Section 4973  
23          (relating to tax on excess contributions to individual re-  
24          tirement accounts, certain section 403(b) contracts, and  
25          certain individual retirement annuities) is amended—

1           (1) by inserting “**MEDICAL SAVINGS AC-**  
2       **COUNTS,**” after “**ACCOUNTS,**” in the heading of  
3       such section,

4           (2) by striking “or” at the end of paragraph  
5       (1) of subsection (a),

6           (3) by redesignating paragraph (2) of sub-  
7       section (a) as paragraph (3) and by inserting after  
8       paragraph (1) the following:

9           “(2) a medical savings account (within the  
10       meaning of section 220(d)), or”, and

11          (4) by adding at the end the following new sub-  
12       section:

13       “(d) **EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS**  
14       **ACCOUNTS.**—For purposes of this section, in the case of  
15       a medical savings accounts (within the meaning of section  
16       220(d)), the term ‘excess contributions’ means the sum  
17       of—

18           “(1) the amount by which the amount contrib-  
19       uted for the taxable year to the accounts (other than  
20       rollover contributions described in section 220(f)(5))  
21       exceeds the amount allowable as a deduction under  
22       section 220 for such contributions, and

23           “(2) the amount determined under this sub-  
24       section for the preceding taxable year, reduced by  
25       the sum of distributions out of the account included

1 in gross income under section 220(f) (2) or (3) and  
2 the excess (if any) of the maximum amount allow-  
3 able as a deduction under section 220 for the tax-  
4 able year over the amount contributed to the ac-  
5 counts.

6 For purposes of this subsection, any contribution which  
7 is distributed out of the medical savings account in a dis-  
8 tribution to which section 220(f)(3) applies shall be treat-  
9 ed as an amount not contributed.”

10 (g) TAX ON PROHIBITED TRANSACTIONS.—

11 (1) Section 4975 (relating to tax on prohibited  
12 transactions) is amended by adding at the end of  
13 subsection (c) the following new paragraph:

14 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-  
15 COUNTS.—An individual for whose benefit a medical  
16 savings account (within the meaning of section  
17 220(d)) is established shall be exempt from the tax  
18 imposed by this section with respect to any trans-  
19 action concerning such account (which would other-  
20 wise be taxable under this section) if, with respect  
21 to such transaction, the account ceases to be a medi-  
22 cal savings account by reason of the application of  
23 section 220(e)(2) to such account.”

24 (2) Paragraph (1) of section 4975(e) is amend-  
25 ed to read as follows:



1           “(1) PLAN.—For purposes of this section, the  
2       term ‘plan’ means—

3           “(A) a trust described in section 401(a)  
4       which forms a part of a plan, or a plan de-  
5       scribed in section 403(a), which trust or plan is  
6       exempt from tax under section 501(a),

7           “(B) an individual retirement account de-  
8       scribed in section 408(a),

9           “(C) an individual retirement annuity de-  
10      scribed in section 408(b),

11          “(D) a medical savings account described  
12      in section 220(d), or

13          “(E) a trust, plan, account, or annuity  
14      which, at any time, has been determined by the  
15      Secretary to be described in any preceding sub-  
16      paragraph of this paragraph.”

17      (h) FAILURE TO PROVIDE REPORTS ON MEDICAL  
18      SAVINGS ACCOUNTS.—

19          (1) Subsection (a) of section 6693 (relating to  
20      failure to provide reports on individual retirement  
21      accounts or annuities) is amended to read as follows:

22      “(a) REPORTS.—

23          “(1) IN GENERAL.—If a person required to file  
24      a report under a provision referred to in paragraph

25      (2) fails to file such report at the time and in the

1 manner required by such provision, such person  
 2 shall pay a penalty of \$50 for each failure unless it  
 3 is shown that such failure is due to reasonable  
 4 cause.

5 “(2) PROVISIONS.—The provisions referred to  
 6 in this paragraph are—

7 “(A) subsections (i) and (l) of section 408  
 8 (relating to individual retirement plans), and

9 “(B) section 220(h) (relating to medical  
 10 savings accounts).”

11 (i) EXCEPTION FROM CAPITALIZATION OF POLICY  
 12 ACQUISITION EXPENSES.—Subparagraph (B) of section  
 13 848(e)(1) (defining specified insurance contract) is  
 14 amended by striking “and” at the end of clause (ii), by  
 15 striking the period at the end of clause (iii) and inserting  
 16 “, and”, and by adding at the end the following new  
 17 clause:

18 “(iv) any contract which is a medical  
 19 savings account (as defined in section  
 20 220(d)).”.

21 (j) CLERICAL AMENDMENTS.—

22 (1) The table of sections for part VII of sub-  
 23 chapter B of chapter 1 is amended by striking the  
 24 last item and inserting the following:

“Sec. 220. Medical savings accounts.  
 “Sec. 221. Cross reference.”.

1           (2) The table of sections for part IV of sub-  
 2           chapter A of chapter 11 is amended by adding at  
 3           the end the following new item:

          “Sec. 2057. Medical savings accounts.”.

4           (k) EFFECTIVE DATE.—The amendments made by  
 5           this section shall apply to taxable years beginning after  
 6           December 31, 1996.

7           **Subtitle B—Increase in Deduction**  
 8           **for Health Insurance Costs of**  
 9           **Self-Employed Individuals**

10          **SEC. 311. INCREASE IN DEDUCTION FOR HEALTH INSUR-**  
 11                               **ANCE COSTS OF SELF-EMPLOYED INDIVID-**  
 12                               **UALS.**

13          (a) IN GENERAL.—Paragraph (1) of section 162(l)  
 14          is amended to read as follows:

15               “(1) ALLOWANCE OF DEDUCTION.—

16                       “(A) IN GENERAL.—In the case of an indi-  
 17                       vidual who is an employee within the meaning  
 18                       of section 401(c)(1), there shall be allowed as  
 19                       a deduction under this section an amount equal  
 20                       to the applicable percentage of the amount paid  
 21                       during the taxable year for insurance which  
 22                       constitutes medical care for the taxpayer, his  
 23                       spouse, and dependents.

24                       “(B) APPLICABLE PERCENTAGE.—For  
 25                       purposes of subparagraph (A), the applicable

1 percentage shall be determined under the fol-  
 2 lowing table:

<b>“For taxable years beginning in calendar year—</b>	<b>The applicable percentage is—</b>
1998 .....	35 percent
1999, 2000, or 2001 .....	40 percent
2002 .....	45 percent
2003 or thereafter .....	50 percent.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
 4 this section shall apply to taxable years beginning after  
 5 December 31, 1997.

## 6 **Subtitle C—Long-Term Care** 7 **Services and Contracts**

### 8 **PART I—GENERAL PROVISIONS**

#### 9 **SEC. 321. TREATMENT OF LONG-TERM CARE INSURANCE.**

10 (a) GENERAL RULE.—Chapter 79 (relating to defini-  
 11 tions) is amended by inserting after section 7702A the fol-  
 12 lowing new section:

#### 13 **“SEC. 7702B. TREATMENT OF QUALIFIED LONG-TERM CARE** 14 **INSURANCE.**

15 “(a) IN GENERAL.—For purposes of this title—

16 “(1) a qualified long-term care insurance con-  
 17 tract shall be treated as an accident and health in-  
 18 surance contract,

19 “(2) amounts (other than policyholder divi-  
 20 dends, as defined in section 808, or premium re-  
 21 funds) received under a qualified long-term care in-  
 22 surance contract shall be treated as amounts re-

1       ceived for personal injuries and sickness and shall be  
2       treated as reimbursement for expenses actually in-  
3       curred for medical care (as defined in section  
4       213(d)),

5           “(3) any plan of an employer providing cov-  
6       erage under a qualified long-term care insurance  
7       contract shall be treated as an accident and health  
8       plan with respect to such coverage,

9           “(4) except as provided in subsection (e)(3),  
10      amounts paid for a qualified long-term care insur-  
11      ance contract providing the benefits described in  
12      subsection (b)(2)(A) shall be treated as payments  
13      made for insurance for purposes of section  
14      213(d)(1)(D), and

15           “(5) a qualified long-term care insurance con-  
16      tract shall be treated as a guaranteed renewable con-  
17      tract subject to the rules of section 816(e).

18      “(b) QUALIFIED LONG-TERM CARE INSURANCE  
19      CONTRACT.—For purposes of this title—

20           “(1) IN GENERAL.—The term ‘qualified long-  
21      term care insurance contract’ means any insurance  
22      contract if—

23           “(A) the only insurance protection pro-  
24      vided under such contract is coverage of quali-  
25      fied long-term care services,

1           “(B) such contract does not pay or reim-  
2           burse expenses incurred for services or items to  
3           the extent that such expenses are reimbursable  
4           under title XVIII of the Social Security Act or  
5           would be so reimbursable but for the applica-  
6           tion of a deductible or coinsurance amount,

7           “(C) such contract is guaranteed renew-  
8           able,

9           “(D) such contract does not provide for a  
10          cash surrender value or other money that can  
11          be—

12                 “(i) paid, assigned, or pledged as col-  
13                 lateral for a loan, or

14                 “(ii) borrowed,  
15          other than as provided in subparagraph (E) or  
16          paragraph (2)(C),

17           “(E) all refunds of premiums, and all pol-  
18           icyholder dividends or similar amounts, under  
19           such contract are to be applied as a reduction  
20           in future premiums or to increase future bene-  
21           fits, and

22           “(F) such contract meets the requirements  
23           of subsection (f).

24          “(2) SPECIAL RULES.—

1           “(A) PER DIEM, ETC. PAYMENTS PER-  
2           MITTED.—A contract shall not fail to be de-  
3           scribed in subparagraph (A) or (B) of para-  
4           graph (1) by reason of payments being made on  
5           a per diem or other periodic basis without re-  
6           gard to the expenses incurred during the period  
7           to which the payments relate.

8           “(B) SPECIAL RULES RELATING TO MEDI-  
9           CARE.—

10           “(i) Paragraph (1)(B) shall not apply  
11           to expenses which are reimbursable under  
12           title XVIII of the Social Security Act only  
13           as a secondary payor.

14           “(ii) No provision of law shall be con-  
15           strued or applied so as to prohibit the of-  
16           fering of a qualified long-term care insur-  
17           ance contract on the basis that the con-  
18           tract coordinates its benefits with those  
19           provided under such title.

20           “(C) REFUNDS OF PREMIUMS.—Paragraph  
21           (1)(E) shall not apply to any refund on the  
22           death of the insured, or on a complete surren-  
23           der or cancellation of the contract, which can-  
24           not exceed the aggregate premiums paid under  
25           the contract. Any refund on a complete surren-

1           der or cancellation of the contract shall be in-  
2           cludible in gross income to the extent that any  
3           deduction or exclusion was allowable with re-  
4           spect to the premiums.

5           “(c) QUALIFIED LONG-TERM CARE SERVICES.—For  
6 purposes of this section—

7           “(1) IN GENERAL.—The term ‘qualified long-  
8 term care services’ means necessary diagnostic, pre-  
9 ventive, therapeutic, curing, treating, mitigating, and  
10 rehabilitative services, and maintenance or personal  
11 care services, which—

12                   “(A) are required by a chronically ill indi-  
13 vidual, and

14                   “(B) are provided pursuant to a plan of  
15 care prescribed by a licensed health care practi-  
16 tioner.

17           “(2) CHRONICALLY ILL INDIVIDUAL.—

18                   “(A) IN GENERAL.—The term ‘chronically  
19 ill individual’ means any individual who has  
20 been certified by a licensed health care practi-  
21 tioner as—

22                           “(i) being unable to perform (without  
23 substantial assistance from another indi-  
24 vidual) at least 2 activities of daily living



1 for a period of at least 90 days due to a  
2 loss of functional capacity,

3 “(ii) having a level of disability simi-  
4 lar (as determined by the Secretary in con-  
5 sultation with the Secretary of Health and  
6 Human Services) to the level of disability  
7 described in clause (i), or

8 “(iii) requiring substantial supervision  
9 to protect such individual from threats to  
10 health and safety due to severe cognitive  
11 impairment.

12 Such term shall not include any individual oth-  
13 erwise meeting the requirements of the preced-  
14 ing sentence unless within the preceding 12-  
15 month period a licensed health care practitioner  
16 has certified that such individual meets such re-  
17 quirements.

18 “(B) ACTIVITIES OF DAILY LIVING.—For  
19 purposes of subparagraph (A), each of the fol-  
20 lowing is an activity of daily living:

21 “(i) Eating.

22 “(ii) Toileting.

23 “(iii) Transferring.

24 “(iv) Bathing.

25 “(v) Dressing.

1 “(vi) Continence.

2 Nothing in this section shall be construed to re-  
3 quire a contract to take into account all of the  
4 preceding activities of daily living.

5 “(3) MAINTENANCE OR PERSONAL CARE SERV-  
6 ICES.—The term ‘maintenance or personal care serv-  
7 ices’ means any care the primary purpose of which  
8 is the provision of needed assistance with any of the  
9 disabilities as a result of which the individual is a  
10 chronically ill individual (including the protection  
11 from threats to health and safety due to severe cog-  
12 nitive impairment).

13 “(4) LICENSED HEALTH CARE PRACTI-  
14 TIONER.—The term ‘licensed health care practi-  
15 tioner’ means any physician (as defined in section  
16 1861(r)(1) of the Social Security Act) and any reg-  
17 istered professional nurse, licensed social worker, or  
18 other individual who meets such requirements as  
19 may be prescribed by the Secretary.

20 “(d) AGGREGATE PAYMENTS IN EXCESS OF LIM-  
21 ITS.—

22 “(1) IN GENERAL.—If the aggregate amount of  
23 periodic payments under all qualified long-term care  
24 insurance contracts with respect to an insured for  
25 any period exceeds the dollar amount in effect for

1       such period under paragraph (3), such excess pay-  
2       ments shall be treated as made for qualified long-  
3       term care services only to the extent of the costs in-  
4       curred by the payee (not otherwise compensated for  
5       by insurance or otherwise) for qualified long-term  
6       care services provided during such period for such  
7       insured.

8               “(2) PERIODIC PAYMENTS.—For purposes of  
9       paragraph (1), the term ‘periodic payment’ means  
10      any payment (whether on a periodic basis or other-  
11      wise) made without regard to the extent of the costs  
12      incurred by the payee for qualified long-term care  
13      services.

14              “(3) DOLLAR AMOUNT.—The dollar amount in  
15      effect under this subsection shall be \$175 per day  
16      (or the equivalent amount in the case of payments  
17      on another periodic basis).

18              “(4) INFLATION ADJUSTMENT.—In the case of  
19      a calendar year after 1997, the dollar amount con-  
20      tained in paragraph (3) shall be increased at the  
21      same time and in the same manner as amounts are  
22      increased pursuant to section 213(d)(10).

23              “(e) TREATMENT OF COVERAGE PROVIDED AS PART  
24      OF A LIFE INSURANCE CONTRACT.—Except as otherwise  
25      provided in regulations prescribed by the Secretary, in the

1 case of any long-term care insurance coverage (whether  
2 or not qualified) provided by a rider on or as part of a  
3 life insurance contract—

4 “(1) IN GENERAL.—This section shall apply as  
5 if the portion of the contract providing such cov-  
6 erage is a separate contract.

7 “(2) APPLICATION OF 7702.—Section  
8 7702(c)(2) (relating to the guideline premium limi-  
9 tation) shall be applied by increasing the guideline  
10 premium limitation with respect to a life insurance  
11 contract, as of any date—

12 “(A) by the sum of any charges (but not  
13 premium payments) against the life insurance  
14 contract’s cash surrender value (within the  
15 meaning of section 7702(f)(2)(A)) for such cov-  
16 erage made to that date under the contract, less

17 “(B) any such charges the imposition of  
18 which reduces the premiums paid for the con-  
19 tract (within the meaning of section  
20 7702(f)(1)).

21 “(3) APPLICATION OF SECTION 213.—No deduc-  
22 tion shall be allowed under section 213(a) for  
23 charges against the life insurance contract’s cash  
24 surrender value described in paragraph (2), unless  
25 such charges are includible in income as a result of

1 the application of section 72(e)(10) and the rider is  
2 a qualified long-term care insurance contract under  
3 subsection (b).

4 “(4) PORTION DEFINED.—For purposes of this  
5 subsection, the term ‘portion’ means only the terms  
6 and benefits under a life insurance contract that are  
7 in addition to the terms and benefits under the con-  
8 tract without regard to the coverage under a quali-  
9 fied long-term care insurance contract.”

10 (b) LONG-TERM CARE INSURANCE NOT PERMITTED  
11 UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING AR-  
12 RANGEMENTS.—

13 (1) CAFETERIA PLANS.—Section 125(f) is  
14 amended by adding at the end the following new  
15 sentence: “Such term shall not include any long-  
16 term care insurance contract (as defined in section  
17 4980C).”

18 (2) FLEXIBLE SPENDING ARRANGEMENTS.—  
19 Section 106 (relating to contributions by employer to  
20 accident and health plans), as amended by section  
21 301(c), is amended by adding at the end the follow-  
22 ing new subsection:

23 “(c) INCLUSION OF LONG-TERM CARE BENEFITS  
24 PROVIDED THROUGH FLEXIBLE SPENDING ARRANGE-  
25 MENTS.—

1           “(1) IN GENERAL.—Effective on and after Jan-  
 2       uary 1, 1997, gross income of an employee shall in-  
 3       clude employer-provided coverage for qualified long-  
 4       term care services (as defined in section 7702B(c))  
 5       to the extent that such coverage is provided through  
 6       a flexible spending or similar arrangement.

7           “(2) FLEXIBLE SPENDING ARRANGEMENT.—  
 8       For purposes of this subsection, a flexible spending  
 9       arrangement is a benefit program which provides  
 10      employees with coverage under which—

11           “(A) specified incurred expenses may be  
 12      reimbursed (subject to reimbursement maxi-  
 13      mums and other reasonable conditions), and

14           “(B) the maximum amount of reimburse-  
 15      ment which is reasonably available to a partici-  
 16      pant for such coverage is less than 500 percent  
 17      of the value of such coverage.

18      In the case of an insured plan, the maximum  
 19      amount reasonably available shall be determined on  
 20      the basis of the underlying coverage.”

21      (c) CONTINUATION COVERAGE EXCISE TAX NOT TO  
 22      APPLY.—Subsection (f) of section 4980B is amended by  
 23      adding at the end the following new paragraph:

24           “(9) CONTINUATION OF LONG-TERM CARE COV-  
 25      ERAGE NOT REQUIRED.—A group health plan shall

1 not be treated as failing to meet the requirements of  
 2 this subsection solely by reason of failing to provide  
 3 coverage under any qualified long-term care insur-  
 4 ance contract (as defined in section 7702B(b)).”

5 (d) CLERICAL AMENDMENT.—The table of sections  
 6 for chapter 79 is amended by inserting after the item re-  
 7 lating to section 7702A the following new item:

“Sec. 7702B. Treatment of qualified long-term care insurance.”.

8 (e) EFFECTIVE DATE.—

9 (1) IN GENERAL.—The amendments made by  
 10 this section shall apply to contracts issued after De-  
 11 cember 31, 1996.

12 (2) CONTINUATION OF EXISTING POLICIES.—In  
 13 the case of any contract issued before January 1,  
 14 1997, which met the long-term care insurance re-  
 15 quirements of the State in which the contract was  
 16 situated at the time the contract was issued—

17 (A) such contract shall be treated for pur-  
 18 poses of the Internal Revenue Code of 1986 as  
 19 a qualified long-term care insurance contract  
 20 (as defined in section 7702B(b) of such Code),  
 21 and

22 (B) services provided under, or reimbursed  
 23 by, such contract shall be treated for such pur-  
 24 poses as qualified long-term care services (as  
 25 defined in section 7702B(c) of such Code).

1           (3) EXCHANGES OF EXISTING POLICIES.—If,  
2           after the date of enactment of this Act and before  
3           January 1, 1998, a contract providing for long-term  
4           care insurance coverage is exchanged solely for a  
5           qualified long-term care insurance contract (as de-  
6           fined in section 7702B(b) of such Code), no gain or  
7           loss shall be recognized on the exchange. If, in addi-  
8           tion to a qualified long-term care insurance contract,  
9           money or other property is received in the exchange,  
10          then any gain shall be recognized to the extent of  
11          the sum of the money and the fair market value of  
12          the other property received. For purposes of this  
13          paragraph, the cancellation of a contract providing  
14          for long-term care insurance coverage and reinvest-  
15          ment of the cancellation proceeds in a qualified long-  
16          term care insurance contract within 60 days there-  
17          after shall be treated as an exchange.

18          (4) ISSUANCE OF CERTAIN RIDERS PER-  
19          MITTED.—For purposes of applying sections 101(f),  
20          7702, and 7702A of the Internal Revenue Code of  
21          1986 to any contract—

22                 (A) the issuance of a rider which is treated  
23                 as a qualified long-term care insurance contract  
24                 under section 7702B, and



1 (B) the addition of any provision required  
2 to conform any other long-term care rider to be  
3 so treated,  
4 shall not be treated as a modification or material  
5 change of such contract.

6 **SEC. 322. QUALIFIED LONG-TERM CARE SERVICES TREAT-**  
7 **ED AS MEDICAL CARE.**

8 (a) GENERAL RULE.—Paragraph (1) of section  
9 213(d) (defining medical care) is amended by striking  
10 “or” at the end of subparagraph (B), by redesignating  
11 subparagraph (C) as subparagraph (D), and by inserting  
12 after subparagraph (B) the following new subparagraph:

13 “(C) for qualified long-term care services  
14 (as defined in section 7702B(c)), or”.

15 (b) TECHNICAL AMENDMENTS.—

16 (1) Subparagraph (D) of section 213(d)(1) (as  
17 redesignated by subsection (a)) is amended by in-  
18 serting before the period “or for any qualified long-  
19 term care insurance contract (as defined in section  
20 7702B(b))”.

21 (2)(A) Paragraph (1) of section 213(d) is  
22 amended by adding at the end the following new  
23 flush sentence:

24 “In the case of a qualified long-term care insurance  
25 contract (as defined in section 7702B(b)), only eligi-

ble long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).”

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraphs:

“(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

“(A) IN GENERAL.—For purposes of this section, the term ‘eligible long-term care premiums’ means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

<b>“In the case of an individual with an attained age before the close of the taxable year of:</b>	<b>The limitation is:</b>
40 or less .....	\$ 200
More than 40 but not more than 50 .....	375
More than 50 but not more than 60 .....	750
More than 60 but not more than 70 .....	2,000
More than 70 .....	2,500.

“(B) INDEXING.—

“(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such

1 amount for such calendar year. If any in-  
2 crease determined under the preceding sen-  
3 tence is not a multiple of \$10, such in-  
4 crease shall be rounded to the nearest mul-  
5 tiple of \$10.

6 “(ii) MEDICAL CARE COST ADJUST-  
7 MENT.—For purposes of clause (i), the  
8 medical care cost adjustment for any cal-  
9 endar year is the percentage (if any) by  
10 which—

11 “(I) the medical care component  
12 of the Consumer Price Index (as de-  
13 fined in section 1(f)(5)) for August of  
14 the preceding calendar year, exceeds

15 “(II) such component for August  
16 of 1996.

17 The Secretary shall, in consultation with  
18 the Secretary of Health and Human Serv-  
19 ices, prescribe an adjustment which the  
20 Secretary determines is more appropriate  
21 for purposes of this paragraph than the  
22 adjustment described in the preceding sen-  
23 tence, and the adjustment so prescribed  
24 shall apply in lieu of the adjustment de-  
25 scribed in the preceding sentence.

1           “(11) CERTAIN PAYMENTS TO RELATIVES  
2           TREATED AS NOT PAID FOR MEDICAL CARE.—An  
3           amount paid for a qualified long-term care service  
4           (as defined in section 7702B(c)) provided to an indi-  
5           vidual shall be treated as not paid for medical care  
6           if such service is provided—

7                   “(A) by the spouse of the individual or by  
8                   a relative (directly or through a partnership,  
9                   corporation, or other entity) unless the service  
10                  is provided by a licensed professional with re-  
11                  spect to such service, or

12                   “(B) by a corporation or partnership which  
13                  is related (within the meaning of section 267(b)  
14                  or 707(b)) to the individual.

15           For purposes of this paragraph, the term ‘relative’  
16           means an individual bearing a relationship to the in-  
17           dividual which is described in any of paragraphs (1)  
18           through (8) of section 152(a). This paragraph shall  
19           not apply for purposes of section 105(b) with respect  
20           to reimbursements through insurance.” .

21           (3) Paragraph (6) of section 213(d) is  
22           amended—

23                   (A) by striking “subparagraphs (A) and  
24                   (B)” and inserting “subparagraphs (A), (B),  
25                   and (C)”, and

1 (B) by striking “paragraph (1)(C)” in sub-  
2 paragraph (A) and inserting “paragraph  
3 (1)(D)”.

4 (4) Paragraph (7) of section 213(d) is amended  
5 by striking “subparagraphs (A) and (B)” and insert-  
6 ing “subparagraphs (A), (B), and (C)”.

7 (c) EFFECTIVE DATE.—

8 (1) IN GENERAL.—The amendments made by  
9 this section shall apply to taxable years beginning  
10 after December 31, 1996.

11 (2) DEDUCTION FOR LONG-TERM CARE SERV-  
12 ICES.—Amounts paid for qualified long-term care  
13 services (as defined in section 7702B(c) of the Inter-  
14 nal Revenue Code of 1986, as added by this Act)  
15 furnished in any taxable year beginning before Janu-  
16 ary 1, 1998, shall not be taken into account under  
17 section 213 of the Internal Revenue Code of 1986.

18 **SEC. 323. REPORTING REQUIREMENTS.**

19 (a) IN GENERAL.—Subpart B of part III of sub-  
20 chapter A of chapter 61 is amended by adding at the end  
21 the following new section:

22 **“SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.**

23 “(a) REQUIREMENT OF REPORTING.—Any person  
24 who pays long-term care benefits shall make a return, ac-

1 cording to the forms or regulations prescribed by the Sec-  
2 retary, setting forth—

3 “(1) the aggregate amount of such benefits  
4 paid by such person to any individual during any  
5 calendar year, and

6 “(2) the name, address, and TIN of such indi-  
7 vidual.

8 “(b) STATEMENTS TO BE FURNISHED TO PERSONS  
9 WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—  
10 Every person required to make a return under subsection  
11 (a) shall furnish to each individual whose name is required  
12 to be set forth in such return a written statement show-  
13 ing—

14 “(1) the name of the person making the pay-  
15 ments, and

16 “(2) the aggregate amount of long-term care  
17 benefits paid to the individual which are required to  
18 be shown on such return.

19 The written statement required under the preceding sen-  
20 tence shall be furnished to the individual on or before Jan-  
21 uary 31 of the year following the calendar year for which  
22 the return under subsection (a) was required to be made.

23 “(c) LONG-TERM CARE BENEFITS.—For purposes of  
24 this section, the term ‘long-term care benefit’ means—

1           “(1) any amount paid under a long-term care  
2           insurance policy (within the meaning of section  
3           4980C(e)), and

4           “(2) payments which are excludable from gross  
5           income by reason of section 101(g).”.

6           (b) PENALTIES.—

7           (1) Subparagraph (B) of section 6724(d)(1) is  
8           amended by redesignating clauses (ix) through (xiv)  
9           as clauses (x) through (xv), respectively, and by in-  
10          serting after clause (viii) the following new clause:

11                       “(ix) section 6050Q (relating to cer-  
12                       tain long-term care benefits),”.

13          (2) Paragraph (2) of section 6724(d) is amend-  
14          ed by redesignating subparagraphs (Q) through (T)  
15          as subparagraphs (R) through (U), respectively, and  
16          by inserting after subparagraph (P) the following  
17          new subparagraph:

18                       “(Q) section 6050Q(b) (relating to certain  
19                       long-term care benefits),”.

20          (c) CLERICAL AMENDMENT.—The table of sections  
21          for subpart B of part III of subchapter A of chapter 61  
22          is amended by adding at the end the following new item:

                      “Sec. 6050Q. Certain long-term care benefits.”.

23          (d) EFFECTIVE DATE.—The amendments made by  
24          this section shall apply to benefits paid after December  
25          31, 1996.

1   **PART II—CONSUMER PROTECTION PROVISIONS**

2   **SEC. 325. POLICY REQUIREMENTS.**

3       Section 7702B (as added by section 321) is amended  
4 by adding at the end the following new subsection:

5       “(f) CONSUMER PROTECTION PROVISIONS.—

6           “(1) IN GENERAL.—The requirements of this  
7 subsection are met with respect to any contract if  
8 any long-term care insurance policy issued under the  
9 contract meets—

10           “(A) the requirements of the model regula-  
11 tion and model Act described in paragraph (2),

12           “(B) the disclosure requirement of para-  
13 graph (3), and

14           “(C) the requirements relating to  
15 nonforfeitability under paragraph (4).

16       “(2) REQUIREMENTS OF MODEL REGULATION  
17 AND ACT.—

18           “(A) IN GENERAL.—The requirements of  
19 this paragraph are met with respect to any pol-  
20 icy if such policy meets—

21           “(i) MODEL REGULATION.—The fol-  
22 lowing requirements of the model regula-  
23 tion:

24           “(I) Section 7A (relating to guar-  
25 anteed renewal or noncancellability),  
26 and the requirements of section 6B of



1 the model Act relating to such section  
2 7A.

3 “(II) Section 7B (relating to pro-  
4 hibitions on limitations and exclu-  
5 sions).

6 “(III) Section 7C (relating to ex-  
7 tension of benefits).

8 “(IV) Section 7D (relating to  
9 continuation or conversion of cov-  
10 erage).

11 “(V) Section 7E (relating to dis-  
12 continuance and replacement of poli-  
13 cies).

14 “(VI) Section 8 (relating to unin-  
15 tentional lapse).

16 “(VII) Section 9 (relating to dis-  
17 closure), other than section 9F there-  
18 of.

19 “(VIII) Section 10 (relating to  
20 prohibitions against post-claims un-  
21 derwriting).

22 “(IX) Section 11 (relating to  
23 minimum standards).

24 “(X) Section 12 (relating to re-  
25 quirement to offer inflation protec-

1                   tion), except that any requirement for  
2                   a signature on a rejection of inflation  
3                   protection shall permit the signature  
4                   to be on an application or on a separate form.  
5

6                   “(XI) Section 23 (relating to prohibition against preexisting conditions  
7                   and probationary periods in replacement policies or certificates).  
8

9                   “(ii) MODEL ACT.—The following requirements of the model Act:  
10  
11

12                   “(I) Section 6C (relating to preexisting conditions).  
13

14                   “(II) Section 6D (relating to prior hospitalization).  
15

16                   “(B) DEFINITIONS.—For purposes of this  
17                   paragraph—

18                   “(i) MODEL PROVISIONS.—The terms  
19                   ‘model regulation’ and ‘model Act’ mean  
20                   the long-term care insurance model regulation, and the long-term care insurance  
21                   model Act, respectively, promulgated by  
22                   the National Association of Insurance  
23                   Commissioners (as adopted as of January  
24                   1993).  
25

1                   “(ii) COORDINATION.—Any provision  
2                   of the model regulation or model Act listed  
3                   under clause (i) or (ii) of subparagraph  
4                   (A) shall be treated as including any other  
5                   provision of such regulation or Act nec-  
6                   essary to implement the provision.

7                   “(iii) DETERMINATION.—For pur-  
8                   poses of this section and section 4980C,  
9                   the determination of whether any require-  
10                  ment of a model regulation or the model  
11                  Act has been met shall be made by the  
12                  Secretary.

13               “(3) DISCLOSURE REQUIREMENT.—The re-  
14               quirement of this paragraph is met with respect to  
15               any policy if such policy meets the requirements of  
16               section 4980C(d)(1).

17               “(4) NONFORFEITURE REQUIREMENTS.—

18               “(A) IN GENERAL.—The requirements of  
19               this paragraph are met with respect to any level  
20               premium long-term care insurance policy, if the  
21               issuer of such policy offers to the policyholder,  
22               including any group policyholder, a  
23               nonforfeiture provision meeting the require-  
24               ments of subparagraph (B).

1           “(B) REQUIREMENTS OF PROVISION.—The  
2 nonforfeiture provision required under subpara-  
3 graph (A) shall meet the following require-  
4 ments:

5           “(i) The nonforfeiture provision shall  
6 be appropriately captioned.

7           “(ii) The nonforfeiture provision shall  
8 provide for a benefit available in the event  
9 of a default in the payment of any pre-  
10 miums and the amount of the benefit may  
11 be adjusted subsequent to being initially  
12 granted only as necessary to reflect  
13 changes in claims, persistency, and interest  
14 as reflected in changes in rates for pre-  
15 mium paying policies approved by the Sec-  
16 retary for the same policy form.

17           “(iii) The nonforfeiture provision shall  
18 provide at least one of the following:

19           “(I) Reduced paid-up insurance.

20           “(II) Extended term insurance.

21           “(III) Shortened benefit period.

22           “(IV) Other similar offerings ap-  
23 proved by the Secretary.

24           “(5) LONG-TERM CARE INSURANCE POLICY DE-  
25 FINED.—For purposes of this subsection, the term

1       ‘long-term care insurance policy’ has the meaning  
2       given such term by section 4980C(e).”.

3   **SEC. 326. REQUIREMENTS FOR ISSUERS OF LONG-TERM**  
4       **CARE INSURANCE POLICIES.**

5       (a) IN GENERAL.—Chapter 43 is amended by adding  
6       at the end the following new section:

7   **“SEC. 4980C. REQUIREMENTS FOR ISSUERS OF LONG-TERM**  
8       **CARE INSURANCE POLICIES.**

9       “(a) GENERAL RULE.—There is hereby imposed on  
10      any person failing to meet the requirements of subsection  
11      (c) or (d) a tax in the amount determined under sub-  
12      section (b).

13      “(b) AMOUNT.—

14           “(1) IN GENERAL.—The amount of the tax im-  
15      posed by subsection (a) shall be \$100 per policy for  
16      each day any requirements of subsection (c) or (d)  
17      are not met with respect to each long-term care in-  
18      surance policy.

19           “(2) WAIVER.—In the case of a failure which is  
20      due to reasonable cause and not to willful neglect,  
21      the Secretary may waive part or all of the tax im-  
22      posed by subsection (a) to the extent that payment  
23      of the tax would be excessive relative to the failure  
24      involved.

1       “(c) RESPONSIBILITIES.—The requirements of this  
2 subsection are as follows:

3           “(1) REQUIREMENTS OF MODEL PROVISIONS.—

4               “(A) MODEL REGULATION.—The following  
5 requirements of the model regulation must be  
6 met:

7                   “(i) Section 13 (relating to application  
8 forms and replacement coverage).

9                   “(ii) Section 14 (relating to reporting  
10 requirements), except that the issuer shall  
11 also report at least annually the number of  
12 claims denied during the reporting period  
13 for each class of business (expressed as a  
14 percentage of claims denied), other than  
15 claims denied for failure to meet the wait-  
16 ing period or because of any applicable  
17 preexisting condition.

18                   “(iii) Section 20 (relating to filing re-  
19 quirements for marketing).

20                   “(iv) Section 21 (relating to standards  
21 for marketing), including inaccurate com-  
22 pletion of medical histories, other than sec-  
23 tions 21C(1) and 21C(6) thereof, except  
24 that—

1           “(I) in addition to such require-  
2           ments, no person shall, in selling or  
3           offering to sell a long-term care insur-  
4           ance policy, misrepresent a material  
5           fact; and

6           “(II) no such requirements shall  
7           include a requirement to inquire or  
8           identify whether a prospective appli-  
9           cant or enrollee for long-term care in-  
10          surance has accident and sickness in-  
11          surance.

12          “(v) Section 22 (relating to appro-  
13          priateness of recommended purchase).

14          “(vi) Section 24 (relating to standard  
15          format outline of coverage).

16          “(vii) Section 25 (relating to require-  
17          ment to deliver shopper’s guide).

18          “(B) MODEL ACT.—The following require-  
19          ments of the model Act must be met:

20               “(i) Section 6F (relating to right to  
21               return), except that such section shall also  
22               apply to denials of applications and any re-  
23               fund shall be made within 30 days of the  
24               return or denial.

1 “(ii) Section 6G (relating to outline of  
2 coverage).

3 “(iii) Section 6H (relating to require-  
4 ments for certificates under group plans).

5 “(iv) Section 6I (relating to policy  
6 summary).

7 “(v) Section 6J (relating to monthly  
8 reports on accelerated death benefits).

9 “(vi) Section 7 (relating to incontest-  
10 ability period).

11 “(C) DEFINITIONS.—For purposes of this  
12 paragraph, the terms ‘model regulation’ and  
13 ‘model Act’ have the meanings given such terms  
14 by section 7702B(f)(2)(B).

15 “(2) DELIVERY OF POLICY.—If an application  
16 for a long-term care insurance policy (or for a cer-  
17 tificate under a group long-term care insurance pol-  
18 icy) is approved, the issuer shall deliver to the appli-  
19 cant (or policyholder or certificateholder) the policy  
20 (or certificate) of insurance not later than 30 days  
21 after the date of the approval.

22 “(3) INFORMATION ON DENIALS OF CLAIMS.—  
23 If a claim under a long-term care insurance policy  
24 is denied, the issuer shall, within 60 days of the date



1 of a written request by the policyholder or  
 2 certificateholder (or representative)—

3 “(A) provide a written explanation of the  
 4 reasons for the denial, and

5 “(B) make available all information di-  
 6 rectly relating to such denial.

7 “(d) DISCLOSURE.—The requirements of this sub-  
 8 section are met if the issuer of a long-term care insurance  
 9 policy discloses in such policy and in the outline of cov-  
 10 erage required under subsection (c)(1)(B)(ii) that the pol-  
 11 icy is intended to be a qualified long-term care insurance  
 12 contract under section 7702B(b).

13 “(e) LONG-TERM CARE INSURANCE POLICY DE-  
 14 FINED.—For purposes of this section, the term ‘long-term  
 15 care insurance policy’ means any product which is adver-  
 16 tised, marketed, or offered as long-term care insurance.”.

17 (b) CONFORMING AMENDMENT.—The table of sec-  
 18 tions for chapter 43 is amended by adding at the end the  
 19 following new item:

“Sec. 4980C. Requirements for issuers of long-term care insur-  
 ance policies.”.

20 **SEC. 327. COORDINATION WITH STATE REQUIREMENTS.**

21 Nothing in this part shall prevent a State from estab-  
 22 lishing, implementing, or continuing in effect standards  
 23 related to the protection of policyholders of long-term care  
 24 insurance policies (as defined in section 4980C(e) of the

1 Internal Revenue Code of 1986), if such standards are not  
 2 in conflict with or inconsistent with the standards estab-  
 3 lished under such Code.

4 **SEC. 328. EFFECTIVE DATES.**

5 (a) IN GENERAL.—The provisions of, and amend-  
 6 ments made by, this part shall apply to contracts issued  
 7 after December 31, 1996. The provisions of section 321(g)  
 8 (relating to transition rule) shall apply to such contracts.

9 (b) ISSUERS.—The amendments made by section 326  
 10 shall apply to actions taken after December 31, 1996.

11 **Subtitle D—Treatment of**  
 12 **Accelerated Death Benefits**

13 **SEC. 331. TREATMENT OF ACCELERATED DEATH BENEFITS**  
 14 **BY RECIPIENT.**

15 (a) IN GENERAL.—Section 101 (relating to certain  
 16 death benefits) is amended by adding at the end the fol-  
 17 lowing new subsection:

18 “(g) TREATMENT OF CERTAIN ACCELERATED  
 19 DEATH BENEFITS.—

20 “(1) IN GENERAL.—For purposes of this sec-  
 21 tion, the following amounts shall be treated as an  
 22 amount paid by reason of the death of an insured:

23 “(A) Any amount received under a life in-  
 24 surance contract on the life of an insured who  
 25 is a terminally ill individual.

1           “(B) Any amount received under a life in-  
2           surance contract on the life of an insured who  
3           is a chronically ill individual (as defined in sec-  
4           tion 7702B(c)(2)) but only if such amount is  
5           received under a rider or other provision of  
6           such contract which is treated as a qualified  
7           long-term care insurance contract under section  
8           7702B and such amount is treated under sec-  
9           tion 7702B (after the application of subsection  
10          (d) thereof) as a payment for qualified long-  
11          term care services (as defined in such section).

12          “(2) TREATMENT OF VIATICAL SETTLE-  
13          MENTS.—

14               “(A) IN GENERAL.—In the case of a life  
15               insurance contract on the life of an insured de-  
16               scribed in paragraph (1), if—

17                       “(i) any portion of such contract is  
18                       sold to any viatical settlement provider, or

19                       “(ii) any portion of the death benefit  
20                       is assigned to such a provider,  
21               the amount paid for such sale or assignment  
22               shall be treated as an amount paid under the  
23               life insurance contract by reason of the death of  
24               such insured.

1 “(B) VIATICAL SETTLEMENT PROVIDER.—

2 The term ‘viatical settlement provider’ means  
3 any person regularly engaged in the trade or  
4 business of purchasing, or taking assignments  
5 of, life insurance contracts on the lives of  
6 insureds described in paragraph (1) if—

7 “(i) such person is licensed for such  
8 purposes in the State in which the insured  
9 resides, or

10 “(ii) in the case of an insured who re-  
11 sides in a State not requiring the licensing  
12 of such persons for such purposes—

13 “(I) such person meets the re-  
14 quirements of sections 8 and 9 of the  
15 Viatical Settlements Model Act of the  
16 National Association of Insurance  
17 Commissioners, and

18 “(II) meets the requirements of  
19 the Model Regulations of the National  
20 Association of Insurance Commis-  
21 sioners (relating to standards for eval-  
22 uation of reasonable payments) in de-  
23 termining amounts paid by such per-  
24 son in connection with such purchases  
25 or assignments.

1           “(3) DEFINITIONS.—For purposes of this sub-  
2       section—

3           “(A) TERMINALLY ILL INDIVIDUAL.—The  
4       term ‘terminally ill individual’ means an indi-  
5       vidual who has been certified by a physician as  
6       having an illness or physical condition which  
7       can reasonably be expected to result in death in  
8       24 months or less after the date of the certifi-  
9       cation.

10          “(B) PHYSICIAN.—The term ‘physician’  
11       has the meaning given to such term by section  
12       1861(r)(1) of the Social Security Act (42  
13       U.S.C. 1395x(r)(1)).

14          “(4) EXCEPTION FOR BUSINESS-RELATED POLI-  
15       CIES.—This subsection shall not apply in the case of  
16       any amount paid to any taxpayer other than the in-  
17       sured if such taxpayer has an insurable interest with  
18       respect to the life of the insured by reason of the in-  
19       sured being a director, officer, or employee of the  
20       taxpayer or by reason of the insured being finan-  
21       cially interested in any trade or business carried on  
22       by the taxpayer.”.

23          (b) EFFECTIVE DATE.—The amendment made by  
24       subsection (a) shall apply to amounts received after De-  
25       cember 31, 1996.

1 **SEC. 332. TAX TREATMENT OF COMPANIES ISSUING QUALI-**  
2 **FIED ACCELERATED DEATH BENEFIT RID-**  
3 **ERS.**

4 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-  
5 ERS TREATED AS LIFE INSURANCE.—Section 818 (relat-  
6 ing to other definitions and special rules) is amended by  
7 adding at the end the following new subsection:

8 “(g) QUALIFIED ACCELERATED DEATH BENEFIT  
9 RIDERS TREATED AS LIFE INSURANCE.—For purposes of  
10 this part—

11 “(1) IN GENERAL.—Any reference to a life in-  
12 surance contract shall be treated as including a ref-  
13 erence to a qualified accelerated death benefit rider  
14 on such contract.

15 “(2) QUALIFIED ACCELERATED DEATH BENE-  
16 FIT RIDERS.—For purposes of this subsection, the  
17 term ‘qualified accelerated death benefit rider’  
18 means any rider on a life insurance contract if the  
19 only payments under the rider are payments meeting  
20 the requirements of section 101(g).

21 “(3) EXCEPTION FOR LONG-TERM CARE RID-  
22 ERS.—Paragraph (1) shall not apply to any rider  
23 which is treated as a long-term care insurance con-  
24 tract under section 7702B.”.

25 (b) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The amendment made by  
2 this section shall take effect on January 1, 1997.

3 (2) ISSUANCE OF RIDER NOT TREATED AS MA-  
4 TERIAL CHANGE.—For purposes of applying sections  
5 101(f), 7702, and 7702A of the Internal Revenue  
6 Code of 1986 to any contract—

7 (A) the issuance of a qualified accelerated  
8 death benefit rider (as defined in section 818(g)  
9 of such Code (as added by this Act)), and

10 (B) the addition of any provision required  
11 to conform an accelerated death benefit rider to  
12 the requirements of such section 818(g),  
13 shall not be treated as a modification or material  
14 change of such contract.

## 15 **Subtitle E—High-Risk Pools**

### 16 **SEC. 341. EXEMPTION FROM INCOME TAX FOR STATE-SPON-** 17 **SORED ORGANIZATIONS PROVIDING HEALTH** 18 **COVERAGE FOR HIGH-RISK INDIVIDUALS.**

19 (a) IN GENERAL.—Subsection (c) of section 501 (re-  
20 lating to list of exempt organizations) is amended by add-  
21 ing at the end the following new paragraph:

22 “(26) Any membership organization if—

23 “(A) such organization is established by a  
24 State exclusively to provide coverage for medical  
25 care (as defined in section 213(d)) on a not-for-

1 profit basis to individuals described in subpara-  
2 graph (B) through—

3 “(i) insurance issued by the organiza-  
4 tion, or

5 “(ii) a health maintenance organiza-  
6 tion under an arrangement with the orga-  
7 nization,

8 “(B) the only individuals receiving such  
9 coverage through the organization are individ-  
10 uals—

11 “(i) who are residents of such State,  
12 and

13 “(ii) who, by reason of the existence  
14 or history of a medical condition, are un-  
15 able to acquire medical care coverage for  
16 such condition through insurance or from  
17 a health maintenance organization or are  
18 able to acquire such coverage only at a  
19 rate which is substantially in excess of the  
20 rate for such coverage through the mem-  
21 bership organization,

22 “(C) the composition of the membership in  
23 such organization is specified by such State,  
24 and



1           “(D) no part of the net earnings of the or-  
 2           ganization inures to the benefit of any private  
 3           shareholder or individual.”.

4           (b) EFFECTIVE DATE.—The amendment made by  
 5 this section shall apply to taxable years beginning after  
 6 December 31, 1996.

## 7   **Subtitle F—Organizations Subject** 8           **to Section 833**

### 9   **SEC. 351. ORGANIZATIONS SUBJECT TO SECTION 833.**

10          (a) IN GENERAL.—Section 833(c) (relating to orga-  
 11 nization to which section applies) is amended by adding  
 12 at the end the following new paragraph:

13               “(4) TREATMENT AS EXISTING BLUE CROSS OR  
 14           BLUE SHIELD ORGANIZATION.—

15               “(A) IN GENERAL.—Paragraph (2) shall  
 16           be applied to an organization described in sub-  
 17           paragraph (B) as if it were a Blue Cross or  
 18           Blue Shield organization.

19               “(B) APPLICABLE ORGANIZATION.—An or-  
 20           ganization is described in this subparagraph if  
 21           it—

22               “(i) is organized under, and governed  
 23           by, State laws which are specifically and  
 24           exclusively applicable to not-for-profit

1 health insurance or health service type or-  
 2 ganizations, and

3 “(ii) is not a Blue Cross or Blue  
 4 Shield organization or health maintenance  
 5 organization.”.

6 (b) EFFECTIVE DATE.—The amendment made by  
 7 this section shall apply to taxable years ending after De-  
 8 cember 31, 1996.

## 9 **TITLE IV—REVENUE OFFSETS**

### 10 **SEC. 400. AMENDMENT OF 1986 CODE.**

11 Except as otherwise expressly provided, whenever in  
 12 this title an amendment or repeal is expressed in terms  
 13 of an amendment to, or repeal of, a section or other provi-  
 14 sion, the reference shall be considered to be made to a  
 15 section or other provision of the Internal Revenue Code  
 16 of 1986.

## 17 **Subtitle A—Repeal of Bad Debt Re-** 18 **serve Method for Thrift Savings** 19 **Associations**

### 20 **SEC. 401. REPEAL OF BAD DEBT RESERVE METHOD FOR** 21 **THRIFT SAVINGS ASSOCIATIONS.**

22 (a) IN GENERAL.—Section 593 (relating to reserves  
 23 for losses on loans) is amended by adding at the end the  
 24 following new subsections:

1       “(f) TERMINATION OF RESERVE METHOD.—Sub-  
 2 sections (a), (b), (c), and (d) shall not apply to any taxable  
 3 year beginning after December 31, 1995.

4       “(g) 6-YEAR SPREAD OF ADJUSTMENTS.—

5           “(1) IN GENERAL.—In the case of any taxpayer  
 6 who is required by reason of subsection (f) to change  
 7 its method of computing reserves for bad debts—

8           “(A) such change shall be treated as a  
 9 change in a method of accounting,

10          “(B) such change shall be treated as initi-  
 11 ated by the taxpayer and as having been made  
 12 with the consent of the Secretary, and

13          “(C) the net amount of the adjustments  
 14 required to be taken into account by the tax-  
 15 payer under section 481(a)—

16           “(i) shall be determined by taking into  
 17 account only applicable excess reserves,  
 18 and

19           “(ii) as so determined, shall be taken  
 20 into account ratably over the 6-taxable  
 21 year period beginning with the first taxable  
 22 year beginning after December 31, 1995.

23       “(2) APPLICABLE EXCESS RESERVES.—

1           “(A) IN GENERAL.—For purposes of para-  
2 graph (1), the term ‘applicable excess reserves’  
3 means the excess (if any) of—

4           “(i) the balance of the reserves de-  
5 scribed in subsection (c)(1) (other than the  
6 supplemental reserve) as of the close of the  
7 taxpayer’s last taxable year beginning be-  
8 fore December 31, 1995, over

9           “(ii) the lesser of—

10           “(I) the balance of such reserves  
11 as of the close of the taxpayer’s last  
12 taxable year beginning before January  
13 1, 1988, or

14           “(II) the balance of the reserves  
15 described in subclause (I), reduced in  
16 the same manner as under section  
17 585(b)(2)(B)(ii) on the basis of the  
18 taxable years described in clause (i)  
19 and this clause.

20           “(B) SPECIAL RULE FOR THRIFTS WHICH  
21 BECOME SMALL BANKS.—In the case of a bank  
22 (as defined in section 581) which was not a  
23 large bank (as defined in section 585(c)(2)) for  
24 its first taxable year beginning after December  
25 31, 1995—

1 “(i) the balance taken into account  
2 under subparagraph (A)(ii) shall not be  
3 less than the amount which would be the  
4 balance of such reserves as of the close of  
5 its last taxable year beginning before such  
6 date if the additions to such reserves for  
7 all taxable years had been determined  
8 under section 585(b)(2)(A), and

9 “(ii) the opening balance of the re-  
10 serve for bad debts as of the beginning of  
11 such first taxable year shall be the balance  
12 taken into account under subparagraph  
13 (A)(ii) (determined after the application of  
14 clause (i) of this subparagraph).

15 The preceding sentence shall not apply for pur-  
16 poses of paragraphs (5) and (6) or subsection  
17 (e)(1).

18 “(3) RECAPTURE OF PRE-1988 RESERVES  
19 WHERE TAXPAYER CEASES TO BE BANK.—If, during  
20 any taxable year beginning after December 31,  
21 1995, a taxpayer to which paragraph (1) applied is  
22 not a bank (as defined in section 581), paragraph  
23 (1) shall apply to the reserves described in para-  
24 graph (2)(A)(ii) and the supplemental reserve; ex-  
25 cept that such reserves shall be taken into account

1       ratably over the 6-taxable year period beginning with  
2       such taxable year.

3               “(4) SUSPENSION OF RECAPTURE IF RESIDEN-  
4       TIAL LOAN REQUIREMENT MET.—

5               “(A) IN GENERAL.—In the case of a bank  
6       which meets the residential loan requirement of  
7       subparagraph (B) for the first taxable year be-  
8       ginning after December 31, 1995, or for the  
9       following taxable year—

10              “(i) no adjustment shall be taken into  
11              account under paragraph (1) for such tax-  
12              able year, and

13              “(ii) such taxable year shall be dis-  
14              regarded in determining—

15              “(I) whether any other taxable  
16              year is a taxable year for which an  
17              adjustment is required to be taken  
18              into account under paragraph (1), and

19              “(II) the amount of such adjust-  
20              ment.

21              “(B) RESIDENTIAL LOAN REQUIRE-  
22       MENT.—A taxpayer meets the residential loan  
23       requirement of this subparagraph for any tax-  
24       able year if the principal amount of the residen-  
25       tial loans made by the taxpayer during such

1           year is not less than the base amount for such  
2           year.

3           “(C) RESIDENTIAL LOAN.—For purposes  
4           of this paragraph, the term ‘residential loan’  
5           means any loan described in clause (v) of sec-  
6           tion 7701(a)(19)(C) but only if such loan is in-  
7           curred in acquiring, constructing, or improving  
8           the property described in such clause.

9           “(D) BASE AMOUNT.—For purposes of  
10          subparagraph (B), the base amount is the aver-  
11          age of the principal amounts of the residential  
12          loans made by the taxpayer during the 6 most  
13          recent taxable years beginning on or before De-  
14          cember 31, 1995. At the election of the tax-  
15          payer who made such loans during each of such  
16          6 taxable years, the preceding sentence shall be  
17          applied without regard to the taxable year in  
18          which such principal amount was the highest  
19          and the taxable year in such principal amount  
20          was the lowest. Such an election may be made  
21          only for the first taxable year beginning after  
22          such date, and, if made for such taxable year,  
23          shall apply to the succeeding taxable year un-  
24          less revoked with the consent of the Secretary.

1           “(E) CONTROLLED GROUPS.—In the case  
2           of a taxpayer which is a member of any con-  
3           trolled group of corporations described in sec-  
4           tion 1563(a)(1), subparagraph (B) shall be ap-  
5           plied with respect to such group.

6           “(5) CONTINUED APPLICATION OF FRESH  
7           START UNDER SECTION 585 TRANSITIONAL RULES.—  
8           In the case of a taxpayer to which paragraph (1) ap-  
9           plied and which was not a large bank (as defined in  
10          section 585(c)(2)) for its first taxable year beginning  
11          after December 31, 1995:

12           “(A) IN GENERAL.—For purposes of deter-  
13          mining the net amount of adjustments referred  
14          to in section 585(c)(3)(A)(iii), there shall be  
15          taken into account only the excess (if any) of  
16          the reserve for bad debts as of the close of the  
17          last taxable year before the disqualification year  
18          over the balance taken into account by such  
19          taxpayer under paragraph (2)(A)(ii) of this sub-  
20          section.

21           “(B) TREATMENT UNDER ELECTIVE CUT-  
22          OFF METHOD.—For purposes of applying sec-  
23          tion 585(c)(4)—

24           “(i) the balance of the reserve taken  
25          into account under subparagraph (B)



1           thereof shall be reduced by the balance  
2           taken into account by such taxpayer under  
3           paragraph (2)(A)(ii) of this subsection,  
4           and

5           “(ii) no amount shall be includible in  
6           gross income by reason of such reduction.

7           “(6) SUSPENDED RESERVE INCLUDED AS SEC-  
8           TION 381(c) ITEMS.—The balance taken into account  
9           by a taxpayer under paragraph (2)(A)(ii) of this  
10          subsection and the supplemental reserve shall be  
11          treated as items described in section 381(c).

12          “(7) CONVERSIONS TO CREDIT UNIONS.—In the  
13          case of a taxpayer to which paragraph (1) applied  
14          which becomes a credit union described in section  
15          501(c) and exempt from taxation under section  
16          501(a)—

17                 “(A) any amount required to be included  
18                 in the gross income of the credit union by rea-  
19                 son of this subsection shall be treated as de-  
20                 rived from an unrelated trade or business (as  
21                 defined in section 513), and

22                 “(B) for purposes of paragraph (3), the  
23                 credit union shall not be treated as if it were  
24                 a bank.

1           “(8) REGULATIONS.—The Secretary shall pre-  
2       scribe such regulations as may be necessary to carry  
3       out this subsection and subsection (e), including reg-  
4       ulations providing for the application of such sub-  
5       sections in the case of acquisitions, mergers, spin-  
6       offs, and other reorganizations.”.

7       (b) CONFORMING AMENDMENTS.—

8           (1) Subsection (d) of section 50 is amended by  
9       adding at the end the following new sentence:  
10      “Paragraphs (1)(A), (2)(A), and (4) of the section 46(e)  
11      referred to in paragraph (1) of this subsection shall not  
12      apply to any taxable year beginning after December 31,  
13      1995.”

14          (2) Subsection (e) of section 52 is amended by  
15      striking paragraph (1) and by redesignating para-  
16      graphs (2) and (3) as paragraphs (1) and (2), re-  
17      spectively.

18          (3) Subsection (a) of section 57 is amended by  
19      striking paragraph (4).

20          (4) Section 246 is amended by striking sub-  
21      section (f).

22          (5) Clause (i) of section 291(e)(1)(B) is amend-  
23      ed by striking “or to which section 593 applies”.

1           (6) Subparagraph (A) of section 585(a)(2) is  
2           amended by striking “other than an organization to  
3           which section 593 applies”.

4           (7)(A) The material preceding subparagraph  
5           (A) of section 593(e)(1) is amended by striking “by  
6           a domestic building and loan association or an insti-  
7           tution that is treated as a mutual savings bank  
8           under section 591(b)” and inserting “by a taxpayer  
9           having a balance described in subsection  
10          (g)(2)(A)(ii)”.

11          (B) Subparagraph (B) of section 593(e)(1) is  
12          amended to read as follows:

13                 “(B) then out of the balance taken into ac-  
14                 count under subsection (g)(2)(A)(ii) (properly  
15                 adjusted for amounts charged against such re-  
16                 serves for taxable years beginning after Decem-  
17                 ber 31, 1987),”.

18          (C) Paragraph (1) of section 593(e) is amended  
19          by adding at the end the following new sentence:  
20          “‘This paragraph shall not apply to any distribution  
21          of all of the stock of a bank (as defined in section  
22          581) to another corporation if, immediately after the  
23          distribution, such bank and such other corporation  
24          are members of the same affiliated group (as defined  
25          in section 1504) and the provisions of section 5(e)

1 of the Federal Deposit Insurance Act (as in effect  
2 on December 31, 1995) or similar provisions are in  
3 effect.”

4 (8) Section 595 is hereby repealed.

5 (9) Section 596 is hereby repealed.

6 (10) Subsection (a) of section 860E is amend-  
7 ed—

8 (A) by striking “Except as provided in  
9 paragraph (2), the” in paragraph (1) and in-  
10 sserting “The”,

11 (B) by striking paragraphs (2) and (4) and  
12 redesignating paragraphs (3) and (5) as para-  
13 graphs (2) and (3), respectively, and

14 (C) by striking in paragraph (2) (as so re-  
15 designated) all that follows “subsection” and  
16 inserting a period.

17 (11) Paragraph (3) of section 992(d) is amend-  
18 ed by striking “or 593”.

19 (12) Section 1038 is amended by striking sub-  
20 section (f).

21 (13) Clause (ii) of section 1042(c)(4)(B) is  
22 amended by striking “or 593”.

23 (14) Subsection (c) of section 1277 is amended  
24 by striking “or to which section 593 applies”.

1           (15) Subparagraph (B) of section 1361(b)(2) is  
2           amended by striking “or to which section 593 ap-  
3           plies”.

4           (16) The table of sections for part II of sub-  
5           chapter H of chapter 1 is amended by striking the  
6           items relating to sections 595 and 596.

7           (c) EFFECTIVE DATES.—

8           (1) IN GENERAL.—Except as otherwise pro-  
9           vided in this subsection, the amendments made by  
10          this section shall apply to taxable years beginning  
11          after December 31, 1995.

12          (2) SUBSECTION (b)(7).—The amendments  
13          made by subsection (b)(7) shall not apply to any dis-  
14          tribution with respect to preferred stock if—

15                (A) such stock is outstanding at all times  
16                after October 31, 1995, and before the distribu-  
17                tion, and

18                (B) such distribution is made before the  
19                date which is 1 year after the date of the enact-  
20                ment of this Act (or, in the case of stock which  
21                may be redeemed, if later, the date which is 30  
22                days after the earliest date that such stock may  
23                be redeemed).

24          (3) SUBSECTION (b)(8).—The amendment  
25          made by subsection (b)(8) shall apply to property

1       acquired in taxable years beginning after December  
2       31, 1995.

3           (4) SUBSECTION (b)(10).—The amendments  
4       made by subsection (b)(10) shall not apply to any  
5       residual interest held by a taxpayer if such interest  
6       has been held by such taxpayer at all times after Oc-  
7       tober 31, 1995.

8       **Subtitle B—Reform of the Earned**  
9       **Income Credit**

10   **SEC. 411. EARNED INCOME CREDIT DENIED TO INDIVID-**  
11                   **UALS NOT AUTHORIZED TO BE EMPLOYED IN**  
12                   **THE UNITED STATES.**

13       (a) IN GENERAL.—Section 32(c)(1) (relating to indi-  
14       viduals eligible to claim the earned income credit) is  
15       amended by adding at the end the following new subpara-  
16       graph:

17                   “(F) IDENTIFICATION NUMBER REQUIRE-  
18       MENT.—The term ‘eligible individual’ does not  
19       include any individual who does not include on  
20       the return of tax for the taxable year—

21                   “(i) such individual’s taxpayer identi-  
22       fication number, and

23                   “(ii) if the individual is married (with-  
24       in the meaning of section 7703), the tax-

1                   payer identification number of such indi-  
2                   vidual's spouse.”.

3           (b) SPECIAL IDENTIFICATION NUMBER.—Section 32  
4 is amended by adding at the end the following new sub-  
5 section:

6           “(l) IDENTIFICATION NUMBERS.—Solely for pur-  
7 poses of subsections (c)(1)(F) and (c)(3)(D), a taxpayer  
8 identification number means a social security number is-  
9 sued to an individual by the Social Security Administra-  
10 tion (other than a social security number issued pursuant  
11 to clause (II) (or that portion of clause (III) that relates  
12 to clause (II)) of section 205(c)(2)(B)(i) of the Social Se-  
13 curity Act).”.

14          (c) EXTENSION OF PROCEDURES APPLICABLE TO  
15 MATHEMATICAL OR CLERICAL ERRORS.—Section  
16 6213(g)(2) (relating to the definition of mathematical or  
17 clerical errors) is amended by striking “and” at the end  
18 of subparagraph (D), by striking the period at the end  
19 of subparagraph (E) and inserting a comma, and by in-  
20 serting after subparagraph (E) the following new subpara-  
21 graphs:

22                   “(F) an omission of a correct taxpayer  
23 identification number required under section 32  
24 (relating to the earned income credit) to be in-  
25 cluded on a return, and

1           “(G) an entry on a return claiming the  
 2           credit under section 32 with respect to net  
 3           earnings from self-employment described in sec-  
 4           tion 32(c)(2)(A) to the extent the tax imposed  
 5           by section 1401 (relating to self-employment  
 6           tax) on such net earnings has not been paid.”.

7           (d) EFFECTIVE DATE.—The amendments made by  
 8           this section shall apply to taxable years beginning after  
 9           December 31, 1995.

10       **Subtitle C—Treatment of Individ-**  
 11       **uals Who Lose United States**  
 12       **Citizenship**

13       **SEC. 421. REVISION OF INCOME, ESTATE, AND GIFT TAXES**  
 14               **ON INDIVIDUALS WHO LOSE UNITED STATES**  
 15               **CITIZENSHIP.**

16           (a) IN GENERAL.—Subsection (a) of section 877 is  
 17           amended to read as follows:

18           “(a) TREATMENT OF EXPATRIATES.—

19               “(1) IN GENERAL.—Every nonresident alien in-  
 20           dividual who, within the 10-year period immediately  
 21           preceding the close of the taxable year, lost United  
 22           States citizenship, unless such loss did not have for  
 23           1 of its principal purposes the avoidance of taxes  
 24           under this subtitle or subtitle B, shall be taxable for  
 25           such taxable year in the manner provided in sub-



1 section (b) if the tax imposed pursuant to such sub-  
2 section exceeds the tax which, without regard to this  
3 section, is imposed pursuant to section 871.

4 “(2) CERTAIN INDIVIDUALS TREATED AS HAV-  
5 ING TAX AVOIDANCE PURPOSE.—For purposes of  
6 paragraph (1), an individual shall be treated as hav-  
7 ing a principal purpose to avoid such taxes if—

8 “(A) the average annual net income tax  
9 (as defined in section 38(c)(1)) of such individ-  
10 ual for the period of 5 taxable years ending be-  
11 fore the date of the loss of United States citi-  
12 zenship is greater than \$100,000, or

13 “(B) the net worth of the individual as of  
14 such date is \$500,000 or more.

15 In the case of the loss of United States citizenship  
16 in any calendar year after 1996, such \$100,000 and  
17 \$500,000 amounts shall be increased by an amount  
18 equal to such dollar amount multiplied by the cost-  
19 of-living adjustment determined under section  
20 1(f)(3) for such calendar year by substituting ‘1994’  
21 for ‘1992’ in subparagraph (B) thereof. Any in-  
22 crease under the preceding sentence shall be round-  
23 ed to the nearest multiple of \$1,000.”.

24 (b) EXCEPTIONS.—

1           (1) IN GENERAL.—Section 877 is amended by  
2       striking subsection (d), by redesignating subsection  
3       (c) as subsection (d), and by inserting after sub-  
4       section (b) the following new subsection:

5       “(c) TAX AVOIDANCE NOT PRESUMED IN CERTAIN  
6       CASES.—

7           “(1) IN GENERAL.—Subsection (a)(2) shall not  
8       apply to an individual if—

9           “(A) such individual is described in a sub-  
10       paragraph of paragraph (2) of this subsection,  
11       and

12           “(B) within the 1-year period beginning on  
13       the date of the loss of United States citizenship,  
14       such individual submits a ruling request for the  
15       Secretary’s determination as to whether such  
16       loss has for 1 of its principal purposes the  
17       avoidance of taxes under this subtitle or subtitle  
18       B.

19       “(2) INDIVIDUALS DESCRIBED.—

20           “(A) DUAL CITIZENSHIP, ETC.—An indi-  
21       vidual is described in this subparagraph if—

22           “(i) the individual became at birth a  
23       citizen of the United States and a citizen  
24       of another country and continues to be a  
25       citizen of such other country, or

1                   “(ii) the individual becomes (not later  
2                   than the close of a reasonable period after  
3                   loss of United States citizenship) a citizen  
4                   of the country in which—

5                   “(I) such individual was born,

6                   “(II) if such individual is mar-  
7                   ried, such individual’s spouse was  
8                   born, or

9                   “(III) either of such individual’s  
10                  parents were born.

11                  “(B) LONG-TERM FOREIGN RESIDENTS.—

12                  An individual is described in this subparagraph  
13                  if, for each year in the 10-year period ending on  
14                  the date of loss of United States citizenship, the  
15                  individual was present in the United States for  
16                  30 days or less. The rule of section  
17                  7701(b)(3)(D)(ii) shall apply for purposes of  
18                  this subparagraph.

19                  “(C) RENUNCIATION UPON REACHING AGE  
20                  OF MAJORITY.—An individual is described in  
21                  this subparagraph if the individual’s loss of  
22                  United States citizenship occurs before such in-  
23                  dividual attains age 18½.

24                  “(D) INDIVIDUALS SPECIFIED IN REGULA-  
25                  TIONS.—An individual is described in this sub-

1 paragraph if the individual is described in a  
2 category of individuals prescribed by regulation  
3 by the Secretary.”

4 (2) TECHNICAL AMENDMENT.—Paragraph (1)  
5 of section 877(b) of such Code is amended by strik-  
6 ing “subsection (c)” and inserting “subsection (d)”.

7 (c) TREATMENT OF PROPERTY DISPOSED OF IN  
8 NONRECOGNITION TRANSACTIONS; TREATMENT OF DIS-  
9 TRIBUTIONS FROM CERTAIN CONTROLLED FOREIGN  
10 CORPORATIONS.—Subsection (d) of section 877, as reded-  
11 icated by subsection (b), is amended to read as follows:

12 “(d) SPECIAL RULES FOR SOURCE, ETC.—For pur-  
13 poses of subsection (b)—

14 “(1) SOURCE RULES.—The following items of  
15 gross income shall be treated as income from sources  
16 within the United States:

17 “(A) SALE OF PROPERTY.—Gains on the  
18 sale or exchange of property (other than stock  
19 or debt obligations) located in the United  
20 States.

21 “(B) STOCK OR DEBT OBLIGATIONS.—  
22 Gains on the sale or exchange of stock issued  
23 by a domestic corporation or debt obligations of  
24 United States persons or of the United States,

1 a State or political subdivision thereof, or the  
2 District of Columbia.

3 “(C) INCOME OR GAIN DERIVED FROM  
4 CONTROLLED FOREIGN CORPORATION.—Any in-  
5 come or gain derived from stock in a foreign  
6 corporation but only—

7 “(i) if the individual losing United  
8 States citizenship owned (within the mean-  
9 ing of section 958(a)), or is considered as  
10 owning (by applying the ownership rules of  
11 section 958(b)), at any time during the 2-  
12 year period ending on the date of the loss  
13 of United States citizenship, more than 50  
14 percent of—

15 “(I) the total combined voting  
16 power of all classes of stock entitled  
17 to vote of such corporation, or

18 “(II) the total value of the stock  
19 of such corporation, and

20 “(ii) to the extent such income or gain  
21 does not exceed the earnings and profits  
22 attributable to such stock which were  
23 earned or accumulated before the loss of  
24 citizenship and during periods that the

1 ownership requirements of clause (i) are  
2 met.

3 “(2) GAIN RECOGNITION ON CERTAIN EX-  
4 CHANGES.—

5 “(A) IN GENERAL.—In the case of any ex-  
6 change of property to which this paragraph ap-  
7 plies, notwithstanding any other provision of  
8 this title, such property shall be treated as sold  
9 for its fair market value on the date of such ex-  
10 change, and any gain shall be recognized for  
11 the taxable year which includes such date.

12 “(B) EXCHANGES TO WHICH PARAGRAPH  
13 APPLIES.—This paragraph shall apply to any  
14 exchange during the 10-year period described in  
15 subsection (a) if—

16 “(i) gain would not (but for this para-  
17 graph) be recognized on such exchange in  
18 whole or in part for purposes of this sub-  
19 title,

20 “(ii) income derived from such prop-  
21 erty was from sources within the United  
22 States (or, if no income was so derived,  
23 would have been from such sources), and

1           “(iii) income derived from the prop-  
2           erty acquired in the exchange would be  
3           from sources outside the United States.

4           “(C)   EXCEPTION.—Subparagraph   (A)  
5           shall not apply if the individual enters into an  
6           agreement with the Secretary which specifies  
7           that any income or gain derived from the prop-  
8           erty acquired in the exchange (or any other  
9           property which has a basis determined in whole  
10          or part by reference to such property) during  
11          such 10-year period shall be treated as from  
12          sources within the United States. If the prop-  
13          erty transferred in the exchange is disposed of  
14          by the person acquiring such property, such  
15          agreement shall terminate and any gain which  
16          was not recognized by reason of such agreement  
17          shall be recognized as of the date of such dis-  
18          position.

19          “(D) SECRETARY MAY EXTEND PERIOD.—  
20          To the extent provided in regulations prescribed  
21          by the Secretary, subparagraph (B) shall be ap-  
22          plied by substituting the 15-year period begin-  
23          ning 5 years before the loss of United States  
24          citizenship for the 10-year period referred to  
25          therein.

1           “(E) SECRETARY MAY REQUIRE RECOGNI-  
2           TION OF GAIN IN CERTAIN CASES.—To the ex-  
3           tent provided in regulations prescribed by the  
4           Secretary—

5                   “(i) the removal of appreciated tan-  
6                   gible personal property from the United  
7                   States, and

8                   “(ii) any other occurrence which  
9                   (without recognition of gain) results in a  
10                  change in the source of the income or gain  
11                  from property from sources within the  
12                  United States to sources outside the Unit-  
13                  ed States,

14               shall be treated as an exchange to which this  
15               paragraph applies.

16           “(3) SUBSTANTIAL DIMINISHING OF RISKS OF  
17           OWNERSHIP.—For purposes of determining whether  
18           this section applies to any gain on the sale or ex-  
19           change of any property, the running of the 10-year  
20           period described in subsection (a) shall be suspended  
21           for any period during which the individual’s risk of  
22           loss with respect to the property is substantially di-  
23           minished by—

24                   “(A) the holding of a put with respect to  
25                   such property (or similar property),



1           “(B) the holding by another person of a  
2           right to acquire the property, or

3           “(C) a short sale or any other trans-  
4           action.”.

5           (d) CREDIT FOR FOREIGN TAXES IMPOSED ON  
6           UNITED STATES SOURCE INCOME.—

7           (1) Subsection (b) of section 877 is amended by  
8           adding at the end the following new sentence: “The  
9           tax imposed solely by reason of this section shall be  
10          reduced (but not below zero) by the amount of any  
11          income, war profits, and excess profits taxes (within  
12          the meaning of section 903) paid to any foreign  
13          country or possession of the United States on any  
14          income of the taxpayer on which tax is imposed sole-  
15          ly by reason of this section.”

16          (2) Subsection (a) of section 877, as amended  
17          by subsection (a), is amended by inserting “(after  
18          any reduction in such tax under the last sentence of  
19          such subsection)” after “such subsection”.

20          (e) COMPARABLE ESTATE AND GIFT TAX TREAT-  
21          MENT.—

22                (1) ESTATE TAX.—

23                    (A) IN GENERAL.—Subsection (a) of sec-  
24                    tion 2107 is amended to read as follows:

25                    “(a) TREATMENT OF EXPATRIATES.—

1           “(1) RATE OF TAX.—A tax computed in accord-  
2           ance with the table contained in section 2001 is  
3           hereby imposed on the transfer of the taxable estate,  
4           determined as provided in section 2106, of every de-  
5           cedent nonresident not a citizen of the United States  
6           if, within the 10-year period ending with the date  
7           of death, such decedent lost United States citizen-  
8           ship, unless such loss did not have for 1 of its prin-  
9           cipal purposes the avoidance of taxes under this sub-  
10          title or subtitle A.

11           “(2) CERTAIN INDIVIDUALS TREATED AS HAV-  
12          ING TAX AVOIDANCE PURPOSE.—

13           “(A) IN GENERAL.—For purposes of para-  
14          graph (1), an individual shall be treated as hav-  
15          ing a principal purpose to avoid such taxes if  
16          such individual is so treated under section  
17          877(a)(2).

18           “(B) EXCEPTION.—Subparagraph (A)  
19          shall not apply to a decedent meeting the re-  
20          quirements of section 877(c)(1).”.

21           “(B) CREDIT FOR FOREIGN DEATH  
22          TAXES.—Subsection (c) of section 2107 is  
23          amended by redesignating paragraph (2) as  
24          paragraph (3) and by inserting after paragraph  
25          (1) the following new paragraph:

1 “(2) CREDIT FOR FOREIGN DEATH TAXES.—

2 “(A) IN GENERAL.—The tax imposed by  
3 subsection (a) shall be credited with the amount  
4 of any estate, inheritance, legacy, or succession  
5 taxes actually paid to any foreign country in re-  
6 spect of any property which is included in the  
7 gross estate solely by reason of subsection (b).

8 “(B) LIMITATION ON CREDIT.—The credit  
9 allowed by subparagraph (A) for such taxes  
10 paid to a foreign country shall not exceed the  
11 lesser of—

12 “(i) the amount which bears the same  
13 ratio to the amount of such taxes actually  
14 paid to such foreign country in respect of  
15 property included in the gross estate as the  
16 value of the property included in the gross  
17 estate solely by reason of subsection (b)  
18 bears to the value of all property subjected  
19 to such taxes by such foreign country, or

20 “(ii) such property’s proportionate  
21 share of the excess of—

22 “(I) the tax imposed by sub-  
23 section (a), over

1                   “(II) the tax which would be im-  
2                   posed by section 2101 but for this  
3                   section.

4                   “(C) PROPORTIONATE SHARE.—For pur-  
5                   poses of subparagraph (B), a property’s propor-  
6                   tionate share is the percentage of the value of  
7                   the property which is included in the gross es-  
8                   tate solely by reason of subsection (b) bears to  
9                   the total value of the gross estate.”.

10                  (C) EXPANSION OF INCLUSION IN GROSS  
11                  ESTATE OF STOCK OF FOREIGN CORPORA-  
12                  TIONS.—Paragraph (2) of section 2107(b) is  
13                  amended by striking “more than 50 percent of”  
14                  and all that follows and inserting “more than  
15                  50 percent of—

16                  “(A) the total combined voting power of all  
17                  classes of stock entitled to vote of such corpora-  
18                  tion, or

19                  “(B) the total value of the stock of such  
20                  corporation,”.

21                  (2) GIFT TAX.—

22                  (A) IN GENERAL.—Paragraph (3) of sec-  
23                  tion 2501(a) is amended to read as follows:

24                  “(3) EXCEPTION.—

1           “(A) CERTAIN INDIVIDUALS.—Paragraph  
2           (2) shall not apply in the case of a donor who,  
3           within the 10-year period ending with the date  
4           of transfer, lost United States citizenship, un-  
5           less such loss did not have for 1 of its principal  
6           purposes the avoidance of taxes under this sub-  
7           title or subtitle A.

8           “(B) CERTAIN INDIVIDUALS TREATED AS  
9           HAVING TAX AVOIDANCE PURPOSE.—For pur-  
10          poses of subparagraph (A), an individual shall  
11          be treated as having a principal purpose to  
12          avoid such taxes if such individual is so treated  
13          under section 877(a)(2).

14          “(C) EXCEPTION FOR CERTAIN INDIVID-  
15          UALS.—Subparagraph (B) shall not apply to a  
16          decedent meeting the requirements of section  
17          877(c)(1).

18          “(D) CREDIT FOR FOREIGN GIFT TAXES.—  
19          The tax imposed by this section solely by reason  
20          of this paragraph shall be credited with the  
21          amount of any gift tax actually paid to any for-  
22          eign country in respect of any gift which is tax-  
23          able under this section solely by reason of this  
24          paragraph.”.

1 (f) COMPARABLE TREATMENT OF LAWFUL PERMA-  
2 NENT RESIDENTS WHO CEASE TO BE TAXED AS RESI-  
3 DENTS.—

4 (1) IN GENERAL.—Section 877 is amended by  
5 redesignating subsection (e) as subsection (f) and by  
6 inserting after subsection (d) the following new sub-  
7 section:

8 “(e) COMPARABLE TREATMENT OF LAWFUL PERMA-  
9 NENT RESIDENTS WHO CEASE TO BE TAXED AS RESI-  
10 DENTS.—

11 “(1) IN GENERAL.—Any long-term resident of  
12 the United States who—

13 “(A) ceases to be a lawful permanent resi-  
14 dent of the United States (within the meaning  
15 of section 7701(b)(6)), or

16 “(B) commences to be treated as a resi-  
17 dent of a foreign country under the provisions  
18 of a tax treaty between the United States and  
19 the foreign country and who does not waive the  
20 benefits of such treaty applicable to residents of  
21 the foreign country,

22 shall be treated for purposes of this section and sec-  
23 tions 2107, 2501, and 6039F in the same manner  
24 as if such resident were a citizen of the United

1 States who lost United States citizenship on the date  
2 of such cessation or commencement.

3 “(2) LONG-TERM RESIDENT.—For purposes of  
4 this subsection, the term ‘long-term resident’ means  
5 any individual (other than a citizen of the United  
6 States) who is a lawful permanent resident of the  
7 United States in at least 8 taxable years during the  
8 period of 15 taxable years ending with the taxable  
9 year during which the event described in subpara-  
10 graph (A) or (B) of paragraph (1) occurs. For pur-  
11 poses of the preceding sentence, an individual shall  
12 not be treated as a lawful permanent resident for  
13 any taxable year if such individual is treated as a  
14 resident of a foreign country for the taxable year  
15 under the provisions of a tax treaty between the  
16 United States and the foreign country and does not  
17 waive the benefits of such treaty applicable to resi-  
18 dents of the foreign country.

19 “(3) SPECIAL RULES.—

20 “(A) EXCEPTIONS NOT TO APPLY.—Sub-  
21 section (c) shall not apply to an individual who  
22 is treated as provided in paragraph (1).

23 “(B) STEP-UP IN BASIS.—Solely for pur-  
24 poses of determining any tax imposed by reason  
25 of this subsection, property which was held by

1           the long-term resident on the date the individ-  
2           ual first became a resident of the United States  
3           shall be treated as having a basis on such date  
4           of not less than the fair market value of such  
5           property on such date. The preceding sentence  
6           shall not apply if the individual elects not to  
7           have such sentence apply. Such an election,  
8           once made, shall be irrevocable.

9           “(4) AUTHORITY TO EXEMPT INDIVIDUALS.—

10          This subsection shall not apply to an individual who  
11          is described in a category of individuals prescribed  
12          by regulation by the Secretary.

13          “(5) REGULATIONS.—The Secretary shall pre-  
14          scribe such regulations as may be appropriate to  
15          carry out this subsection, including regulations pro-  
16          viding for the application of this subsection in cases  
17          where an alien individual becomes a resident of the  
18          United States during the 10-year period after being  
19          treated as provided in paragraph (1).”.

20          (2) CONFORMING AMENDMENTS.—

21                (A) Section 2107 is amended by striking  
22                subsection (d), by redesignating subsection (e)  
23                as subsection (d), and by inserting after sub-  
24                section (d) (as so redesignated) the following  
25                new subsection:



1 “(e) CROSS REFERENCE.—

“**For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).**”.

2 (B) Paragraph (3) of section 2501(a) (as  
3 amended by subsection (e)) is amended by add-  
4 ing at the end the following new subparagraph:

5 “(E) CROSS REFERENCE.—

“**For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).**”.

6 (g) EFFECTIVE DATE.—

7 (1) IN GENERAL.—The amendments made by  
8 this section shall apply to—

9 (A) individuals losing United States citi-  
10 zenship (within the meaning of section 877 of  
11 the Internal Revenue Code of 1986) on or after  
12 February 6, 1995, and

13 (B) long-term residents of the United  
14 States with respect to whom an event described  
15 in subparagraph (A) or (B) of section 877(e)(1)  
16 of such Code occurs on or after February 6,  
17 1995.

18 (2) SPECIAL RULE.—

19 (A) IN GENERAL.—In the case of an indi-  
20 vidual who performed an act of expatriation  
21 specified in paragraph (1), (2), (3), or (4) of  
22 section 349(a) of the Immigration and Nation-

1            ality Act (8 U.S.C. 1481(a)(1)–(4)) before Feb-  
2            ruary 6, 1995, but who did not, on or before  
3            such date, furnish to the United States Depart-  
4            ment of State a signed statement of voluntary  
5            relinquishment of United States nationality con-  
6            firming the performance of such act, the  
7            amendments made by this section and section  
8            11349 shall apply to such individual except  
9            that—

10            (i) the 10-year period described in  
11            section 877(a) of such Code shall not ex-  
12            pire before the end of the 10-year period  
13            beginning on the date such statement is so  
14            furnished, and

15            (ii) the 1-year period referred to in  
16            section 877(c) of such Code, as amended  
17            by this section, shall not expire before the  
18            date which is 1 year after the date of the  
19            enactment of this Act.

20            (B) EXCEPTION.—Subparagraph (A) shall  
21            not apply if the individual establishes to the  
22            satisfaction of the Secretary of the Treasury  
23            that such loss of United States citizenship oc-  
24            curred before February 6, 1994.

1 **SEC. 422. INFORMATION ON INDIVIDUALS LOSING UNITED**  
2 **STATES CITIZENSHIP.**

3 (a) IN GENERAL.—Subpart A of part III of sub-  
4 chapter A of chapter 61 is amended by inserting after sec-  
5 tion 6039E the following new section:

6 **“SEC. 6039F. INFORMATION ON INDIVIDUALS LOSING UNIT-**  
7 **ED STATES CITIZENSHIP.**

8 “(a) IN GENERAL.—Notwithstanding any other pro-  
9 vision of law, any individual who loses United States citi-  
10 zenship (within the meaning of section 877(a)) shall pro-  
11 vide a statement which includes the information described  
12 in subsection (b). Such statement shall be—

13 “(1) provided not later than the earliest date of  
14 any act referred to in subsection (c), and

15 “(2) provided to the person or court referred to  
16 in subsection (c) with respect to such act.

17 “(b) INFORMATION TO BE PROVIDED.—Information  
18 required under subsection (a) shall include—

19 “(1) the taxpayer’s TIN,

20 “(2) the mailing address of such individual’s  
21 principal foreign residence,

22 “(3) the foreign country in which such individ-  
23 ual is residing,

24 “(4) the foreign country of which such individ-  
25 ual is a citizen,

1           “(5) in the case of an individual having a net  
2           worth of at least the dollar amount applicable under  
3           section 877(a)(2)(B), information detailing the as-  
4           sets and liabilities of such individual, and

5           “(6) such other information as the Secretary  
6           may prescribe.

7           “(c) ACTS DESCRIBED.—For purposes of this sec-  
8           tion, the acts referred to in this subsection are—

9           “(1) the individual’s renunciation of his United  
10          States nationality before a diplomatic or consular of-  
11          ficer of the United States pursuant to paragraph (5)  
12          of section 349(a) of the Immigration and Nationality  
13          Act (8 U.S.C. 1481(a)(5)),

14          “(2) the individual’s furnishing to the United  
15          States Department of State a signed statement of  
16          voluntary relinquishment of United States national-  
17          ity confirming the performance of an act of expatria-  
18          tion specified in paragraph (1), (2), (3), or (4) of  
19          section 349(a) of the Immigration and Nationality  
20          Act (8 U.S.C. 1481(a)(1)–(4)),

21          “(3) the issuance by the United States Depart-  
22          ment of State of a certificate of loss of nationality  
23          to the individual, or

1           “(4) the cancellation by a court of the United  
2       States of a naturalized citizen’s certificate of natu-  
3       ralization.

4           “(d) PENALTY.—Any individual failing to provide a  
5       statement required under subsection (a) shall be subject  
6       to a penalty for each year (of the 10-year period beginning  
7       on the date of loss of United States citizenship) during  
8       any portion of which such failure continues in an amount  
9       equal to the greater of—

10           “(1) 5 percent of the tax required to be paid  
11       under section 877 for the taxable year ending during  
12       such year, or

13           “(2) \$1,000,  
14       unless it is shown that such failure is due to reasonable  
15       cause and not to willful neglect.

16           “(e) INFORMATION TO BE PROVIDED TO SEC-  
17       RETARY.—Notwithstanding any other provision of law—

18           “(1) any Federal agency or court which collects  
19       (or is required to collect) the statement under sub-  
20       section (a) shall provide to the Secretary—

21           “(A) a copy of any such statement, and

22           “(B) the name (and any other identifying  
23       information) of any individual refusing to com-  
24       ply with the provisions of subsection (a),

1           “(2) the Secretary of State shall provide to the  
2       Secretary a copy of each certificate as to the loss of  
3       American nationality under section 358 of the Immi-  
4       gration and Nationality Act which is approved by  
5       the Secretary of State, and

6           “(3) the Federal agency primarily responsible  
7       for administering the immigration laws shall provide  
8       to the Secretary the name of each lawful permanent  
9       resident of the United States (within the meaning of  
10      section 7701(b)(6)) whose status as such has been  
11      revoked or has been administratively or judicially de-  
12      termined to have been abandoned.

13   Notwithstanding any other provision of law, not later than  
14   30 days after the close of each calendar quarter, the Sec-  
15   retary shall publish in the Federal Register the name of  
16   each individual losing United States citizenship (within  
17   the meaning of section 877(a)) with respect to whom the  
18   Secretary receives information under the preceding sen-  
19   tence during such quarter.

20           “(f) REPORTING BY LONG-TERM LAWFUL PERMA-  
21   NENT RESIDENTS WHO CEASE TO BE TAXED AS RESI-  
22   DENTS.—In lieu of applying the last sentence of sub-  
23   section (a), any individual who is required to provide a  
24   statement under this section by reason of section  
25   877(e)(1) shall provide such statement with the return of

1 tax imposed by chapter 1 for the taxable year during  
2 which the event described in such section occurs.

3 “(g) EXEMPTION.—The Secretary may by regula-  
4 tions exempt any class of individuals from the require-  
5 ments of this section if he determines that applying this  
6 section to such individuals is not necessary to carry out  
7 the purposes of this section.”.

8 (b) CLERICAL AMENDMENT.—The table of sections  
9 for such subpart A is amended by inserting after the item  
10 relating to section 6039E the following new item:

“Sec. 6039F. Information on individuals losing United States citizenship.”.

11 (c) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply to—

13 (1) individuals losing United States citizenship  
14 (within the meaning of section 877 of the Internal  
15 Revenue Code of 1986) on or after February 6,  
16 1995, and

17 (2) long-term residents of the United States  
18 with respect to whom an event described in subpara-  
19 graph (A) or (B) of section 877(e)(1) of such Code  
20 occurs on or after such date.

21 In no event shall any statement required by such amend-  
22 ments be due before the 90th day after the date of the  
23 enactment of this Act.

1 **SEC. 423. REPORT ON TAX COMPLIANCE BY UNITED STATES**  
2 **CITIZENS AND RESIDENTS LIVING ABROAD.**

3 Not later than 90 days after the date of the enact-  
4 ment of this Act, the Secretary of the Treasury shall pre-  
5 pare and submit to the Committee on Ways and Means  
6 of the House of Representatives and the Committee on  
7 Finance of the Senate a report—

8 (1) describing the compliance with subtitle A of  
9 the Internal Revenue Code of 1986 by citizens and  
10 lawful permanent residents of the United States  
11 (within the meaning of section 7701(b)(6) of such  
12 Code) residing outside the United States, and

13 (2) recommending measures to improve such  
14 compliance (including improved coordination be-  
15 tween executive branch agencies).

Passed the House of Representatives March 28,  
1996.

Attest:

*Clerk.*